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

Homeland Security

AUDITOR INFORMATION			
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Saint Paul		
Field Office Director:	Peter Berg		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Hall County Department of Corrections		
Physical address:	110 Public Safety Drive, Grand Island, NE 68801		
Mailing address: *(if different from above)*			
Telephone number:	308-385-5211		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	308-385-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Staff Sergeant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	308-385-(b) (6), (b) (7)(C)

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 Hall County Department of Corrections (HCDC) met 14 standards, had 2 standard that was non-applicable, and had 25 non-compliant standards. As a result of the facility being out of compliance with 25 standards, the facility entered a 180-day corrective action period which began on May 16, 2023, through November 12, 2023. The purpose of the corrective action plan is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Initially Not Met: 25

§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.35 Specialized training: Medical and mental health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.71 Criminal and administrative investigations
§115.77 Corrective action for contractors and volunteers
§115.81 Medical and mental health screenings; 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

The facility submitted documentation, through the Agency, for the CAP on June 9, 2023, through November 11, 2023. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on November 17, 2023. In a review of the submitted documentation, to demonstrate compliance with the deficient standards, the Auditor determined compliance with 18 of the standards, and found that 7 standards: continued to be non-complaint based on submitted documentation or lack thereof.

Number of Standards Met: 18

§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.64 Responder duties
§115.67 Agency protection against retaliation
§115.71 Criminal and administrative investigations

§115.77 Corrective action for contractors and volunteers
§115.81 Medical and mental health screenings; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.86 Sexual abuse incident reviews

Number of Standards Not Met: 7
§115.13 Detainee supervision and monitoring
§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.35 Specialized training: Medical and mental health care
§115.42 Use of assessment information
§115.65 Coordinated response
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

PROVISIONS

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

§115. 13 - Detainee supervision and monitoring
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d): HCDC policy 3C-21(a) mandates, "Security staff provides the inmate supervision necessary to protect inmates from sexual abuse/harassment." HCDC policy 3C-21(a) further mandates, "The agency uses video monitoring systems and other cost-effective and appropriate technology to supplement its sexual abuse/harassment prevention, detection, and response efforts. The agency assesses, at least annually, the feasibility of and need for new or additional monitoring technology and develops a plan for securing such technology." HCDC policy 3C-07, Inspections, mandates, "The Shift Supervisor shall complete a Supervisor Unit Inspection sheet and document the completion of the daily tour in the Logbook and personnel log. Staff are prohibited from alerting other staff that these Supervisory rounds are occurring." A review of the facility PAQ indicated HCDC has a total of 74 security staff, consisting of 47 males and 27 females, who may have recurring contact with detainees. The remaining staff consists of support personnel in administration, maintenance, and food service. The facility staffing also includes eight medical contract staff employed by ACH. During the audit period, HCDC custody line staff were working two 12-hour shifts, 0700-1900 and 1900-0700. During the on-site tour the Auditor did observe appropriate staffing levels in the booking area and housing units where detainees are housed. There are a total of (b) (7)(E) strategically located throughout the facility. Video cameras operate 24/7 and have pan, zoom, and tilt, (PTZ) functionality. Cameras are continuously monitored by a staff member in the (b) (7)(E) Video feed can be observed in (b) (7)(E) and on the office computers of the (b) (7)(E), (b) (7)(E), and (b) (7)(E). During the on-site tour, the Auditor observed adequate cameras within the (b) (7)(E) and (b) (7)(E). In addition, the Auditor observed staff sight lines and camera views in the area which provided some privacy; however, the Auditor observed (b) (7)(E) that would enable direct viewing in the booking area within the housing units and direct viewing into shower areas (b) (7)(E) of several housing units. In an Interview with the PSA Compliance Manager, it was indicated that the facility does not use a staff-to-detainee ratio and required security checks are mandated for each housing unit that provide for sufficient supervision of detainees. The PSA Compliance Manager further confirmed he has access to camera footage that can be download in the (b) (7)(E) and saved for needed evidence. The Auditor reviewed three different days of supervisor unit inspection checklists and confirmed the supervisor was conducting the mandated unannounced sanitation and safety inspections required by HCDC Post Order 3A-01; however, the purpose of the rounds was not to identify and deter sexual abuse of detainees as required by subsection (d) of the standard. The Auditor reviewed 16 comprehensive supervision guidelines and confirmed 15 of the 16 comprehensive supervision guidelines had been reviewed in 2022. The facility did not provide documentation to confirm when determining adequate levels of detainee supervision and the need for video monitoring the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendation of sexual abuse incident review reports, or any other relevant factors, including but not limited to, the length of time detainees spend in Agency custody.

Does Not Meet (c)(d): The facility is not in compliance with subsections (c) and (d) of the standard. The facility did not provide documentation to confirm when determining adequate levels of detainee supervision and the need for video monitoring the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendation of sexual abuse incident review reports, or any other relevant factors, including but not limited to, the length of time detainees spend in Agency custody. In addition, the Auditor reviewed three different days of supervisor unit inspection checklists and confirmed the supervisor was conducting the mandated unannounced sanitation and safety inspections required HCDC Post Order 3A-01; however, the purpose of the rounds was not to identify and deter sexual abuse of detainees as required by subsection (d) of the standard. To become compliant, the facility must provide the Auditor with documentation to confirm when determining adequate staffing levels and the need for video monitoring, the facility took into consideration the physical layout of each holding facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors, including but not limited to the length of time detainees spend in Agency Custody. In addition, the facility must implement a practice that requires supervisors to make frequent unannounced security inspections on both day and night shifts to identify and deter sexual abuse of detainees as required by the standard. Once implemented the facility must submit

documentation to confirm all supervisors were trained in conducting unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees. In addition, the facility must submit to the Auditor documentation of unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees for each month of the Corrective Action Plan (CAP) period.

Corrective Action (c)(d): The facility submitted updated policy HCDC-3C-07, Inspections, which confirms updated policy HCDC-3C-07 requires unannounced security inspections must be conducted to identify and deter sexual abuse of detainees. The facility submitted four pictures of post logbooks in Units H/B/C which confirm supervisors are conducting unannounced security inspections on both day and night shifts and at irregular times. The facility submitted training rosters which confirm all supervisors were trained on the requirement to conduct unannounced security inspections on both day and night shifts. The facility provided a memorandum to "whom it may concern" which indicated HCDC reviews all provisions of subsection (c) during annual reviews of policy and procedures; however, the memorandum does not confirm the staffing plan and need for video monitoring was reviewed taking into account all elements of subsection (c) of the standard. Upon review of all submitted documentation, or lack thereof, the Auditor now finds the facility in compliance with subsection (d) of the standard; however, the Auditor continues to find the facility does not meet subsection (c).

§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)(g)(i)(j): HCDC policy 3C-21(a) mandates, "Except in the case of emergency, the facility prohibits cross-gender strip and visual body cavity searches. Except in the case of emergency or other extraordinary or unforeseen circumstances, the facility restricts nonmedical staff from viewing inmates of the opposite gender who are nude or performing bodily functions and similarly restricts cross-gender pat-down searches. All cross-gender searches will be documented." HCDC policy 3C-21(a) further mandates, "The facility shall not allow for the searching or physical examination of a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or if necessary, the learning of that information as part of a broader medical examination conducted in private by a medical practitioner. Upon entering an opposite gender housing unit, staff shall announce their presence." A review of HCDC policy 3C-21(a) confirms it does not contain the verbiage "Cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances" or "cross-gender pat down searches of female detainees shall not be conducted unless in exigent circumstances." In addition, a review of HCDC policy 3C-21(a) confirms it does not require that all strip searches and body cavity searches be documented as required by subsection (f) of the standard. The Auditor reviewed a facility memo which states, "The Hall County Detention Center does not do cross-gender pat down searches;" however, in interviews with five random detention deputies and a first-line supervisor it was indicated although staff do not ordinarily conduct cross-gender searches (pat-down, strip or body cavity) should one be necessary, due to an emergency situation, the search would be documented electronically in the facility Spillman system. In addition, in an interview with five detention deputies it was indicated detainee strip searches would additionally be documented on the U.S. Department of Justice Immigration and Naturalization Service Record of Search Form. In interviews with five random detention deputies and a first-line supervisor it was further indicated that a search or physical examination of a detainee for the sole purpose of identifying a detainee's genital status is never allowed; however, interviews could not confirm that all strip searches and body cavity searches would be documented. The Auditor reviewed a video of staff conducting a pat-down search and confirmed staff conducting the pat down search was the same gender as the detainee being searched. During the on-site tour, although the Auditor did not observe cross-gender issues when it came to detainees changing clothing, the Auditor observed (b) (7)(E) that would enable direct viewing in the booking area and within some of the housing units and direct viewing into shower areas (b) (7)(E) of several housing units. In addition, the Auditor observed staff of the opposite gender announcing their presence as they entered male or female housing units. In interviews with five random detention deputies and a first-line supervisor it was indicated all have received training in proper procedures for conducting pat-down searches including in a professional and respectful manner and in the least intrusive manner possible. The Auditor reviewed the HCDC training curriculum for pat-down searches and confirmed it included cross-gender pat-down searches and searches of transgender and intersex detainees. In addition, the training curriculum included the requirement that all pat-down searches will be conducted in a professional and respectful manner and in the least intrusive manner possible. During an interview with the training officer the Auditor confirmed that training is conducted electronically through a system entitled RELIAS. The Auditor reviewed the training records of three HCDC staff and confirmed all three had received training as required by the standard. The facility does not house juvenile detainees.

Does Not Meet (f)(g): The facility is not in compliance with subsections (f) and (g) of the standard. A review of HCDC policy 3C-21(a) confirms it does not require that all strip searches and body cavity searches will be documented as required by subsection (f) of the standard. In addition, during the on-site tour the Auditor observed (b) (7)(E) that would enable direct viewing in the booking area and within the housing units. In addition, the Auditor observed direct viewing into shower areas

(b) (7)(E) of several housing units. To become compliant, the facility must develop a practice that requires all strip and body cavity searches be documented and not just cross-gender. Once implemented the facility must provide documentation that all detention deputies and first line supervisors have been trained on the requirement to document all strip and body cavity searches. In addition, the facility must implement a practice that provides privacy for all detainees to shower and perform bodily functions without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine jail checks. Once implemented the facility must provide the Auditor with documentation that confirms the cross-gender viewing issues are no longer a concern.

Corrective Action (f)(g): The facility submitted a memorandum to all medical staff which confirms medical staff have been directed to announce their presence when entering the booking area to prevent cross-gender viewing of detainees while showering, performing bodily functions, or changing their clothing. In addition, the facility submitted pictures to confirm the top steps have been covered to prevent cross-gender viewing into shower areas (b) (7)(E) of several housing units. The facility submitted an email sent to all staff with read receipts confirming all detention deputies and first line supervisors have been trained on the requirement to document all strip and body cavity searches. The facility submitted documentation which confirms a strip search conducted at the facility was documented on a G-1025 form and entered in the Spillman computer system. Upon review of all available documentation the Auditor now finds the facility in compliance with subsections (f) and (g) of the standard.

§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): HCDC policy 61-07, Disability Identification Assessment and Accommodation, mandates, "Throughout the facility's programs and activities, including at all stages of the reasonable accommodation process, the facility must take appropriate steps to allow for effective communication with detainees with disabilities to afford them an equal opportunity to participate in, and enjoy the benefits of, the facility's programs and activities. Steps to ensure effective communication may include the provision and use of auxiliary aids or services for detainees with vision, hearing, sensory, speech, and manual impairments, as needed. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual detainee, the nature, length, and complexity of the communication involved, and the context in which the communication is taking place. In determining what types of auxiliary aids or services are necessary, the facility shall give primary consideration to the request of the detainee with a disability. Use of other detainees to interpret or facilitate communication with a detainee with a disability may only occur in emergencies." A review of the facility handbook confirms it contains the facility's zero-tolerance policy and information on how to report an allegation of sexual abuse; however, the handbook was only available in English and Spanish on-site. In an interview with booking staff, it was indicated the ICE National Detainee Handbook would be distributed to the detainee in English and Spanish only if he/she didn't have one. During the on-site tour, the Auditor observed posted above the telephone and on the walls the DHS-prescribed sexual assault awareness notice, reporting numbers for the DRIL, the contact information for the DHS OIG, HCDC zero-tolerance poster, the DHS-prescribed SAA Information pamphlet, and a poster that advised the detainee the contact information for the foreign consulate's office. All observed postings were in English and Spanish except for the HCDC zero-tolerance poster which was posted in English only. In addition, the Auditor observed handheld devices utilized by floor staff. These devices interface with the Guardian System utilized by HCDC and provides staff with a means to utilize Google Translate to communicate with detainees as needed. The Auditor also observed kiosk machines on the housing units run by CIDNET Communications and confirmed information provided on this system was in English and Spanish only. During the on-site tour the PSA Compliance Manager attempted to locate the ICE National Detainee Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-prescribed SAA Information pamphlet available in the remaining 13 most prevalent languages encounter by ICE: Portuguese, Arabic, Hindi, Punjabi, Chinese, Haitian Creole, and French; however, not all could be located. In an interview with the OIC it was indicated that a Talk to Text (TTY) machine is available for facility use to provide detainees who are deaf or hard of hearing with the required PREA information; however, during interviews with booking staff they indicated the TTY machine was not used and they were unable to articulate how the TTY machine worked. In addition, in interviews with booking staff it was indicated they would use multiple ways to provide PREA information to detainees who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities, and those who have limited reading skills including, but not limited to, speaking slowly for those detainees who have intellectual or psychiatric disabilities, speaking, louder for those detainees who have a hearing disability, and reading material or providing written communication for those detainees who may have a vision disability. However, in interviews with booking staff it was confirmed they could not articulate how to use the language line or the alternative verbal and written methods they noted they would use. During interviews with six detainees, it was indicated that three of the four remembered receiving an ICE National Detainee Handbook; however, only two remembered receiving a facility handbook. Three detainees interviewed reported they could not speak with staff during booking/processing and advised staff they need assistance in translation and interpretation; however, the only time the language line had been utilized for communication was during the on-site interview with the Auditor.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. During the on-site tour the Auditor confirmed the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet was available on-site to the detainee population in English and Spanish: however, the PSA Compliance Manager attempted to locate the ICE National Detainee Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-prescribed SAA Information pamphlet remaining in the 13 additional most prevalent languages encounter by ICE: Portuguese, Arabic, Hindi, Punjabi, Chinese, Haitian Creole, and French; however, not all could be located. Interviews with booking staff and detainees confirmed the facility provides PREA information to the detainee in English and Spanish only. In addition, although during interviews with booking staff it was indicated PREA information would be given in alternative ways they could not articulate how to use the language line, TTY machine, or the alternative verbal and written methods to give detainees the information. In interviews with three LEP detainees it was indicated that the only time the facility language line was used was during the Auditors on-site interview. To become compliant, the facility must take appropriate steps to ensure detainees with disabilities, including those who are LEP, have equal access to all aspects of the Agency and facility's efforts to prevent, detect, and respond to sexual abuse. In addition, the facility must implement a practice that includes having the DHS-Prescribed SAA Information pamphlet, in the 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) and the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) available to the detainee on-site. Once implemented the facility must submit documentation that all booking staff have been trained on the new practice. The facility must submit to the Auditor 10 detainee files that include detainees who are received at HCDC during the CAP period to confirm the new practice has been implemented. If applicable, the submitted files should include a sampling of detainees who are LEP, deaf or hard of hearing, blind or have limited sight, or may have intellectual, psychiatric, or a speech disability.

Corrective Action (a)(b)(c): The facility submitted an email to staff providing instruction on how to access the ICE National Detainee Handbook and DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlets in the most prevalent languages encountered by ICE. The facility submitted a "Booking" policy change and screen shots of folders which confirm the ICE National Detainee Handbook and SAA Information pamphlets are available on a shared drive for staff at the facility. The facility submitted an email sent to all staff, including booking staff, which confirms booking staff have been trained on the facility's updated practice to ensure detainees with disabilities, including those who are LEP, have equal access to all aspects of the Agency and facility's efforts to prevent, detect, and respond to sexual abuse to include distributing during the intake process the DHS-Prescribed SAA Information pamphlet, in the 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) and the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The facility submitted six signed memorandums confirming the HCDC Zero Tolerance information was translated into Spanish to include the name if the officer who translated the material and the detainee's signature. The facility submitted a memorandum to Auditor which confirms HCDC has not received any detainees who are deaf or hard of hearing, blind or have limited sight, or may have intellectual, psychiatric, or a speech disability during the CAP period. Upon review of all available information the Auditor now finds the facility in substantial compliance with subsections (a), (b) and (c) of the standard.

§115. 17 - Hiring and promotion decisions
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." The ICE Personnel Security and Suitability Program policy outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." HCDC policy 3C-21(a), mandates, "The agency does not hire or promote anyone who has engaged in sexual abuse/harassment in an institutional setting or who has engaged in sexual activity in the community facilitated by force, the threat of force, or coercion. Consistent with Federal, State, and local law, the agency makes its best

effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse/harassment; must run criminal background investigation for all contractors, volunteers, applicants and employees being considered for employment or promotion; and must examine and carefully weigh any history of criminal activity at work or in the community, including convictions for domestic violence, stalking, and sex-offenses. Background investigations will be performed on all contracted staff, volunteers, and employees every 3 years. The agency also asks all applicants and employees directly about previous misconduct during interviews and reviews." A review of HCDC policy 3C-21(a) confirms it does not include the requirements to not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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 prior to promotion staff shall be asked about previous misconduct during an interview or by written application. The Auditor reviewed the employee application and could not confirm material omissions regarding sexual misconduct or the providing of materially false information would be grounds for termination or withdrawal of an offer of employment. In an interview with an HR representative it was indicated new hires must complete a background investigation successfully prior to hire and the PREA related questions are included in both the employment documents and as part of the promotional process; however, the HR representative could not confirm the facility would not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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. The HR representative further indicated that unless prohibited by law the facility would share any relevant information on substantiated allegations of sexual abuse involving a former employee applying to a different institutional employer. The Auditor reviewed 12 staff personnel files and confirmed initial, and five year required background checks completed in all 12 files; however, only 1 staff personnel file included a signature on a yearly performance review that asked, "Have you engaged in sexual harassment or sexual abuse with an inmate or staff member?" A further review of the yearly performance review confirmed it does not require the employee to disclose all required elements of subsection (a) of the standard. In an interview with an ICE SDDO it was indicated there have not been any new hires or promotions for ICE staff during the audit period. The Auditor submitted a Background Investigation for Employees and Contractors form to the OPR PSO Unit which included three ICE employees assigned to the facility to verify the completion of the background process. OPR PSO confirmed background investigations were completed for all staff submitted.

Does Not Meet (a)(b)(e): The facility is not in compliance with subsections (a), (b) and (e) of the standard. A review of HCDC policy 3C-21(a) confirms it does not include the requirements to not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse or who has been civilly or administratively adjudicated to have engaged in such activity. In an interview with an HR representative it was indicated new hires must complete a background investigation successfully prior to hire and the PREA related questions are included both in the employment documents and as part of the promotional process; however, the HR representative could not confirm the facility would not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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 prior to promotion staff shall be asked about previous misconduct during an interview or by written application. The Auditor reviewed the employee application and could not confirm material omissions regarding sexual misconduct or the providing of materially false information would be grounds for termination or withdrawal of an offer of employment. The Auditor reviewed 12 staff personnel files and confirmed only 1 staff personnel file included a signature on a yearly performance review that asked, "Have you engaged in sexual harassment or sexual abuse with an inmate or staff member?" A further review of the yearly performance review confirmed it does not require the employee to disclose all required elements of subsection (a) of the standard. To become compliant, the facility must implement a practice to not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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 and material omissions regarding sexual misconduct or the providing of materially false information would be grounds for termination or withdrawal of an offer of employment and provide the Auditor with documentation that the practice has been implemented. In addition, the facility must update the yearly performance review to include all the required elements of subsection (a) of the standard. Once implemented the facility must provide documentation that all HR staff have been trained on the new practice. In addition, the facility must provide the Auditor with 15 personnel files that confirm that both practices have been implemented and that staff have a continuing affirmative duty to report any misconduct involving sexual abuse as required by subsection (a).

Corrective Action (a)(b)(e): The facility submitted a blank PREA training form to be utilized for outside contractors which states, "I completely understand all of the information covered in the Hall County Department of Corrections Prison Rape Elimination Act (PREA) Training." The facility submitted 18 PREA employment questionnaires and 1 contractor questionnaire which confirm all were signed post-employment or utilization of services; and therefore, the Auditor accepts

the submitted documentation to confirm the facility has implemented a practice which requires staff have a continuing affirmative duty to report any misconduct involving sexual abuse as required by subsection (b) of the standard. The facility submitted a photo of one contractor binder which included a background check. The facility submitted a memorandum which confirmed HCDC has had two employees start and four outside contractors needing access to the facility since implementation of the new procedure. In addition, the facility submitted two PREA Employment Questionnaires for the new employees and four contractor PREA Employment Questionnaires; however, a review of the submitted documentation confirmed both PREA Employment Applications were completed on the day of hire; and therefore, the Auditor could not confirm if the document was considered in the employment process or was completed on the day the employees were hired. In addition, the Auditor reviewed the four "other" contractor PREA Employment Questionnaires submitted and confirmed two "other" contractors contracted to provide services during the CAP period completed the PREA Employment Application on the day of hire; and therefore, the Auditor could not confirm if the document was considered prior to the "other" contractor providing services or was completed on the day the services were provided. The facility submitted an email which confirms HR staff have been trained on the new procedure; however, documentation submitted cannot confirm a new procedure had been implemented. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility continues to not meet subsections (a), (b) and (e) of the standard.

§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)(b)(c)(d)(e): The Agency's policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." HCDC policy 3C-21(a) mandates, "The agency follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol must be adapted from or otherwise based on the 2004 U.S. Department of Justice's Office on Violence Against Women publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," subsequent updated editions, or similarly comprehensive and authoritative protocols developed after 2004. As part of the Hall County Department of Corrections evidence collection protocol, all victims of inmate-on-inmate sexual abuse or staff-on-inmate sexual abuse are provided access to forensic medical exams performed by qualified forensic medical examiners. Forensic medical exams are provided free of charge to the victim. The facility makes available a victim advocate to accompany the victim through the forensic medical exam process." A review of HCDC policy 3C-21(a) and an interview with the SDDO confirmed the policy was developed in coordination with DHS. The Auditor reviewed a signed Memorandum of Understanding (MOU) dated January 13, 2020, between HCDC and the Crisis Center of Grand Island with no listed end date and confirmed services provided by the Crisis Center of Grand Island will include emotional support, crisis intervention, information and referrals, and a victim advocate to ensure that a victim's interests are represented. In addition, the Auditor reviewed a MOU signed on January 23, 2020, between HCDC and the Director of Emergency Services for Catholic Health Initiative (CHI) St. Francis with no end date that confirmed CHI St. Francis, will provide the expertise of two Sexual Assault Nurse Examiners (SANE) to provide services to HCDC as needed. The Auditor was provided documentation signed on March 13, 2023, by the Sheriff of Hall County that provides for criminal investigations for inmate-on-inmate situations. Additionally, should a conflict arise, such as staff-on-inmate situation, the case would be turned over to the Hall County Attorney's office who will request that an outside agency investigate. This MOU also provides for a detainee housed under contract with the DHS with contact to that agency and involvement in the case. Interviews with the OIC, PSA Compliance Manager, and facility Investigator confirmed that should an allegation of sexual abuse or assault occur the incident would be reported immediately to ICE/ERO. The OIC further indicated Hall County Sheriff's Department would be notified to refer criminal behavior for prosecution or refer the incident back to HCDC for an administrative investigation. In an interview with the facility RN, it was confirmed that the facility would utilize the services of CHI St. Francis during an incident of sexual abuse for forensic examinations and this treatment would be provided free of charge for the detainee. The facility submitted a memorandum from the Sheriff of Hall County confirming that the Hall County Sheriff's Department will investigate all criminal activity that occurs at HCDC; however, the facility did not submit documentation that they requested the Hall County Sheriff's Department follow the requirements of (a) through (d) of the standard. A review of two sexual abuse allegation investigation files indicated that no detainee was sent to the hospital for a forensic medical exam during the audit period. The facility does not house juvenile detainees.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. The facility submitted a memorandum from the Sheriff of Hall County confirming that the Hall County Sheriff's Department will investigate all criminal activity that occurs at HCDC; however, the facility did not submit documentation that they requested the Hall

County Sheriff's Department follow the requirements of (a) through (d) of the standard. To become compliant, the facility must provide documentation that they have requested that the Hall County Sheriff's Department follow the requirements of subsections (a) through (d) of the standard.

Corrective Action (e): The facility submitted an email which confirms the facility has requested the Hall County Sheriff's Office to follow the requirements of subsections (a) – (d) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (e) of the standard.

§115. 22 - Policies to ensure investigation of allegations and appropriate agency oversight
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d)(e)(f): The Agency provided policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly, if necessary, b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE Significant Event Notification (SEN) Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." HCDC policy 3C-21 mandates, "The facility shall employ procedures for an internal administrative investigation that shall be conducted in all cases only after consultation with the assigned criminal investigative entity or after the criminal investigation has concluded. Such procedures shall establish the coordination and sequencing of the two types of investigations, to ensure that the criminal investigation is not compromised by an internal administrative investigation. All incidents and allegations of sexual abuse or assault shall be reported immediately." HCDC policy 3C-21 further states, When an inmate(s) is alleged to be the perpetrator, it is the Director's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and report to Field Office Director (when ICE detainee (s) involved" and "when an employee, contractor, or volunteer is alleged to the perpetrator of inmate sexual abuse or assault it is the Director's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and report to Field Office Director (when ICE detainee (s) involved." In addition, HCDC policy C3-21 states, "The Department retains all reports for as long as the alleged abuser is incarcerated or is employed by the Department plus five years." A review of HCDC policy 3C-21 confirms the policy does include the description of responsibilities of the agency, facility, and any other investigating entities as required by subsection (a) of the standard. In addition, a review of HCDC policy C3-21 confirms it does not contain the verbiage when a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (e) or the verbiage when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (f) of the standard. In interviews with the OIC, PSA Compliance Manager, and facility Investigator it was indicated all allegations of sexual abuse would be referred for investigation and that such records will be maintained in hard copy and electronic format for at least 10 years. Interviews further indicated when a detainee, prisoner, inmate, or resident of the facility where the detainee victim is a housed is alleged to be the perpetrator of detainee sexual abuse or staff member, contractor or volunteer is the perpetrator of detainee sexual abuse, the facility will notify the appropriate ICE FOD and appropriate investigative authority. In an interview with the SDDO it was indicated notification to the JIC would be made immediately upon notification from HCDC. The Auditor reviewed the PREA allegation spread sheet provided with the PAQ and confirmed both closed cases were referred to ICE OPR and the JIC. During a review of the Agency and the facility website, it was confirmed that the Agency website does include the Agency protocol and is located (https://www.ice.gove/detain/prea); however, the facility protocol for investigations HCDC policy C3-21 is not made available to the public on the HCDC website www.hallcountyne.gov/content.lasso?page=7497&.

Does Not Meet (a)(b)(c)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (c), (d), (e) and (f) of the standard. A review of HCDC policy 3C-21 confirms the policy does not include the description of responsibilities of the agency, facility, and any other investigating entities as required by subsection (a) of the standard. In addition, a review of HCDC policy C3-21 confirms it does not contain the verbiage when a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident s promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (e) or the verbiage when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (f) of the standard. The Auditor reviewed the HCDC website

www.hallcountyne.gov/content.lasso?page=7497& and confirmed it does not include the facility investigative protocol HCDC policy C3-21. To become compliant, the facility must update HCDC policy C3-21 to include a description of the responsibilities of the agency, facility, and any other investigating entities and the verbiage "when a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG" and "when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG." Once implemented the facility must submit documentation that all applicable staff have been trained on the updated protocol. In addition, the facility must include the facility protocol, HCDC policy C3-21, on the facility's website www.hallcountyne.gov/content.lasso?–age=7497&.

Corrective Action (a)(b)(c)(d)(e)(f): The facility submitted updated policy HCDC-3C-21 which confirms updated policy HCDC-3C-21 includes the standard's requirement a description of the responsibilities of the agency, facility, and any other investigating entities and the standard's requirement "when a detainee or inmate in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG" and "when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG." The facility submitted an email with read receipts sent to applicable staff which confirms all applicable staff have been trained on updated policy HCDC-3C-21. The Auditor reviewed the facility website www.hallcountyne.gov/content.lasso?–age=7497& and confirmed facility policy C3-21 (a) has been placed on the facility website; however, a review of HCDC policy C3-21 (a) confirms updated policy C3-21 (a) does not include the standard's requirements "when a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG" and "when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG." Upon review of all submitted documentation, or lack thereof, the Auditor now finds the facility in compliance with subsections (a), (b), (c), (d), and (f) of the standard; however, continues to find the facility does not meet subsection (e).

§115. 31 - Staff training

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

Notes:

(a)(b)(c): HCDC policy 3C-21 mandates, "The agency trains all employees to be able to fulfill their responsibilities under agency sexual abuse/harassment prevention, detection, and response policies and procedures; the PREA standards; and relevant Federal, State, and local law. The agency trains all employees to communicate effectively and professionally with all inmates. Additionally, the agency 'rains all employees on an inmate's right to be free from sexual abuse/harassment, the right of inmates and employees to be free from retaliation for reporting sexual abuse/harassment, the dynamics of sexual abuse/harassment in confinement, and the common reactions of sexual abuse/harassment victims. Current employees are educated as soon as possible following the agency's adoption of the PREA standards, and the agency provides at a minimum every 2-year refresher information to all employees to ensure they know the agency's most current sexual abuse/harassment policies and procedures. The agency maintains written documentation showing employee signatures verifying that employees understand the training they have received." The Auditor reviewed the facility PREA training curriculum which includes: the facility's zero-tolerance policy, definitions and examples of prohibited and illegal sexual behavior, rights of detainees and staff to be free from sexual abuse and retaliation for reporting sexual abuse, recognition of situations where sexual abuse may occur, recognition of physical, behavioral and emotional signs of sexual abuse, how to avoid inappropriate relationships with detainees, and facility procedures for reporting knowledge or suspicion of sexual abuse. However, a review of the facility PREA training curriculum confirmed it does not include the Agency's zero-tolerance policy, the requirement to limit reporting of sexual abuse to personnel on a need-to-know basis in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes, or how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees. The Auditor reviewed the RELIAS training system and confirmed staff receive documented refresher training every two years as required by subsection (b) of the standard. In addition, the Auditor reviewed ICE staff training records documented on PALMS and confirmed ICE staff received training as required by the standard.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of the facility PREA training curriculum confirmed it does not include the Agency's zero-tolerance policy, the requirement to limit reporting of sexual abuse to personnel on a need-to-know basis in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes, or how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees. To become compliant, the facility must submit documentation that the facility PREA training curriculum includes all elements of subsection (a) of the standard. In

addition, the facility must provide documentation that all staff who have contact with detainees have received training on the–updated curriculum.

Corrective Action (a): n The facility submitted a copy of the updated PREA lesson plan which confirms the updated PREA lesson plan includes the standard's requirements to limit reporting of sexual abuse to personnel on a need-to-know basis in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes and to speak professionally to detainees including those who identify as lesbian, gay, bisexual, transgender, intersex, or gender nonconforming. The facility submitted an email to all staff to include an attached training outline and read receipts from all staff confirming all staff have received training on the standard's requirements. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§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): HCDC policy 3A-21(a) mandates, "The agency ensures that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency's sexual abuse/harassment prevention, detection, and response policies and procedures; the PREA standards; and relevant Federal, State, and local law. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with inmates, but all volunteers and contractors who have contact with inmate's must be notified of the agency's zero-tolerance policy regarding sexual abuse/harassment. Volunteers must also be trained in how to report sexual abuse/harassment. The agency maintains written documentation showing volunteer and contractor signatures verifying that they understand the training they have received." The Auditor reviewed the HCDC Volunteer Orientation and Training Manual. In addition, the Auditor reviewed PREA training acknowledgement forms submitted by the facility and confirmed volunteers are notified of the agency and facility zero-tolerance policies regarding sexual abuse and are informed on how to report such incidents; however, in an interview with the PSA Compliance Manager it was confirmed other contractors, as outlined in subsection (d) of the standard, are not provided training on their responsibilities under the Agency and the facility sexual abuse prevention, detection, intervention and response policies and procedures.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. In an interview with the PSA Compliance Manager, it was confirmed the facility does not provide other contractors, as outlined in subsection (d) of the standard, the Agency and facility zero-tolerance policies regarding sexual abuse or does the facility inform other contractors how to report incidents of sexual abuse. To become compliant the facility must submit documentation to the Auditor that all other contractors, as outlined in subsection (d) of the standard, have received training on the Agency's and facility's zero-tolerance policies regarding sexual abuse and how to report an incident of sexual abuse.

Corrective Action (a)(b)(c): The facility submitted an updated contractor training curriculum which confirms the updated contractor training curriculum includes how to report an incident of sexual abuse and the Agency facility zero-tolerance policies. The facility submitted training sign off sheets which confirm all "other" contractors have received training as required by standard 115.32. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b) and (c) of 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)(d)(e)(f): HCDC policy 3C-21(a) mandates, "During the intake process staff informs inmates of the agency's zero-tolerance policy regarding sexual abuse/harassment and how to report incidents or suspicions of sexual abuse/harassment. Within a reasonably brief period of time following the intake process, the agency provides comprehensive education to inmates regarding their right to be free from sexual abuse/harassment and to be free from retaliation for reporting abuse/harassment, the dynamics of sexual abuse/harassment in confinement, the common reactions of sexual abuse/harassment victims, and agency sexual abuse/harassment response policies and procedures." HCDC policy 3C-21(a) further states, "The agency provides inmate education in formats accessible to all inmates, including those who are LEP, deaf, visually impaired, or otherwise disabled as well as inmates who have limited reading skills. The agency maintains written documentation of inmate participation in these education sessions." During the on-site tour, the Auditor observed posted above the telephone and on the walls the DHS-prescribed sexual assault awareness notice, reporting numbers for the DRIL, the contact information for the DHS OIG, the telephone number of the Crisis Center, Inc., the DHS-prescribed SAA Information pamphlet, and a poster that advised the detainee the contact information for the foreign consulate's office. All observed postings were in English and Spanish except for the HCDC zero-tolerance poster, which included the name of the PSA Compliance Manager, which was posted in English only. In addition, the Auditor accessed the housing unit kiosks and confirmed the kiosks contained the HCDC zero-tolerance poster, in English only, ICE PREA information in English and Spanish, contact information for the foreign consulate offices, ICE Hope poster, the DHS-prescribed sexual abuse and

assault awareness notice, the ICE National Detainee Handbook in English and Spanish, the facility handbook in English and Spanish and the PREA orientation video in English and Spanish. During the on-site tour the PSA Compliance Manager attempted to locate the ICE National Detainee Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali; and the DHS-prescribed SAA Information pamphlet available in the remaining 13 most prevalent languages encountered by ICE: Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese ; however, not all were located. The Auditor reviewed the HCDC orientation PowerPoint presentation and confirmed it contained facility specific information on what a detainee should do it they are sexually assaulted; however, the information is available in English and Spanish only. In an interview with the OIC it was indicated that a Talk to Text (TTY) machine is available for facility use to provide detainees who are deaf or hard of hearing with the required PREA information; however, during interviews with booking staff they indicated the TTY machine was not used and they were unable to articulate how the TTY machine worked. In addition, in interviews with booking staff it was indicated they would use multiple ways to provide PREA information to detainees who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities, and those who have limited reading skills including, but not limited to, speaking slowly for those detainees who have intellectual or psychiatric disabilities, speaking, louder for those detainees who have a hearing disability, and reading material or providing written communication for those detainees who may have a vision disability. However, in interviews with booking staff it was confirmed they could not articulate how to use the language line or the alternative verbal and written methods they noted they would use. In addition, in interviews with booking staff, it was indicated the facility handbook can be printed in additional languages as needed; however, booking staff could not articulate how this would be accomplished or in what languages the facility handbook could be printed. During interviews with six detainees, it was indicated that three of the four remembered receiving an ICE National Detainee Handbook; however, only two remembered receiving a facility handbook. Three detainees interviewed reported they could not speak with staff during booking/processing and that they needed assistance in translation and interpretation; however, the only time the language line had been utilized for communication was during the on-site interview with the Auditor. The Auditor reviewed a Receipt for Property and Personal Use Items Issued document and confirmed the detainee signs that they have viewed an orientation video, and they understand it and that the document includes a line for "PREA received and understands." The Auditor reviewed six detainee files and confirmed all detainees signed for PREA education received at intake; however, the Auditor could not confirm the information was provided in a manner that all detainees could understand. The Auditor reviewed the ICE National Detainee Handbook and confirmed it included information on how to report an incident of sexual abuse; however, the Auditor could not confirm that the ICE National Detainee Handbook or DHS-prescribed SAA pamphlet Information pamphlet was available on-site, in other than English and Spanish, or could booking staff articulate how the ICE National Detainee Handbook or DHS-prescribed SAA pamphlet Information pamphlet would be provided in another language if need be. In an interview with booking staff, it could not be confirmed if the video included a closed-caption function for the deaf or hard of hearing.

Does Not Meet (a)(b)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (d), (e), and (f) of the standard. A review of HDCD policy confirms within a reasonably brief period of time following the intake process the facility will provide the detainee with orientation. In addition, a review of a detainee signed "Receipt for Property and Personal Use Items Issued" could not confirm what PREA orientation the detainee received simply stating "PREA received and understands." During the on-site tour, the Auditor observed posted above the telephone and on the walls the telephone number of the Crisis Center, Inc., in English and Spanish, and the HCDC zero-tolerance poster, which included the name of the PSA Compliance Manager, in English only. The Auditor reviewed the ICE National Detainee Handbook and confirmed it included information on how to report an incident of sexual abuse; however, the Auditor could not confirm that the ICE National Detainee Handbook or DHS-prescribed SAA Information pamphlet was available on-site, in other than English and Spanish, or could booking staff articulate how the ICE National Detainee Handbook or DHS-prescribed SAA Information pamphlet would be provided in another language if need be. During the on-site audit the PSA Compliance Manager attempted to locate the ICE National Detainee Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-prescribed SAA Information pamphlet available in the remaining 13 most prevalent languages encountered by ICE: Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, they could not be located. The Auditor reviewed HCDC orientation PowerPoint presentation and confirmed it contained facility specific information on what a detainee should do if they are sexually assaulted; however, the information was only available in English and Spanish. Interviews with booking staff and detainees confirmed the facility provides PREA information to the detainee in English and Spanish only. In addition, although during interviews with booking staff it was indicated PREA information would be given in alternative ways they could not articulate how to use the language line, TTY machine, or the alternative verbal and written methods to give detainees the information. In interviews with booking staff, it was indicated the facility handbook could be printed in additional languages as needed; however, booking staff could not articulate in what additional languages the facility handbook could be printed or by what method. To become compliant, the facility must develop and implement a PREA Orientation program during the intake

process that includes each element required in subsection (a) of the standard in a manner they can understand. The facility must make available and distribute during the orientation process the DHS-prescribed SAA Information pamphlet available in the most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian). The facility must post the DHS-prescribed sexual abuse and assault awareness notice, or the HCDC zero-tolerance poster, with the name of the PSA Compliance Manager; and information regarding Crisis Center, Inc. on all housing unit bulletin boards in a manner that all detainees can understand, including detainees who do not speak English, and submit documentation the signage has been posted. The facility must provide the information available in the orientation video to detainees in a manner all detainees can understand. In addition, the facility must provide the Auditor with 10 detainee files, which include detainees who do not speak English or Spanish, and if applicable, detainees who are blind or have limited sight, who are deaf or hard of hearing, or otherwise disabled, to confirm they are participating in an orientation program during the intake process, to include, but is not limited to, the orientation video, the facility handbook, and the DHS-prescribed SAA Information pamphlet in a manner they can understand.

Corrective Action (a)(b)(d)(e)(f): The facility submitted an email to staff providing instruction on how to access the ICE National Detainee Handbook and DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlets in the most prevalent languages encountered by ICE. The facility submitted updated Booking policy HCDC-4A-08. The Auditor reviewed updated Booking policy HCDC-4A-08 and confirmed updated Booking policy HCDC-4A-08 requires the booking officer to ensure all PREA information, including the PREA parts of the orientation video, the DHS Prescribed SAA Information pamphlet, and the ICE National Detainee Handbook be provided to every detainee in a language/manner they can understand. The facility submitted screen shots of folders which confirm the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlets are available on a shared drive for staff at the facility. The facility submitted an email sent to all staff, including booking staff, which confirms booking staff have been trained on the facility's updated practice to ensure detainees with disabilities, including those who are LEP, have equal access to all aspects of the Agency and facility's efforts to prevent, detect, and respond to sexual abuse to include distributing during the intake process the DHS-Prescribed SAA Information pamphlet, in the 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) and the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The facility submitted six signed memorandums confirming the HCDC Zero Tolerance information was translated into Spanish to include the name if the officer who translated the material and the detainee's signature. The facility submitted an updated HCDC zero tolerance poster which confirms the poster includes the name of the PSA Compliance Manager; and information regarding Crisis Center, Inc. posted in housing units A, B, C, D, E, F, G and H. The facility submitted a memorandum to Auditor which confirms HCDC has not received any detainees who are deaf or hard of hearing, blind or have limited sight, or may have intellectual, psychiatric, or a speech disability during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), (d), (e) and (f) of the standard.

§115. 35 - Specialized training: Medical and mental health care
Outcome: Does not Meet Standard
Notes:

(b)(c): HCDC policy 3C-21(a) mandates, "The agency ensures that all full- and part-time medical and mental health care practitioners working in its facilities have been trained in how to detect and assess signs of sexual abuse/harassment and that all medical practitioners are trained in how to preserve physical evidence of sexual abuse. All medical and mental health care practitioners must be trained in how to respond effectively and professionally to victims of sexual abuse/harassment and how and to whom to report allegations or suspicions of sexual abuse/harassment. The agency maintains documentation that medical and mental health practitioners have received this specialized training." A review of HCDC policy 3C-21(a) and an interview with the SDDO confirmed the policy was reviewed and approved by the agency. In an interview with a facility RN it was indicated mandatory specialized training has been completed through Advanced Correctional Healthcare (ACH); however, the Auditor was not provided with a complete training curriculum or staff training records; and therefore, could not confirm all elements of subsection (b) are included in the training or that all medical and mental health staff have received the training as required by the standard.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. In an interview with a RN, it was indicated mandatory specialized training has been completed through ACH; however, the Auditor was not provided a complete training curriculum or staff training records; and therefore, could not confirm all elements of subsection (b) are included in the training or that all medical and mental health staff have received the training as required by the standard. To become compliant, the facility must provide a copy of the training curriculum to confirm it is compliant with subsection (b) of the standard. If it is not, the facility must develop and implement a training curriculum that meets the standards

requirements. In addition, the facility must provide the Auditor with documentation that all medical and mental health staff have received the training as required by subsection (b) of the standard**.**

Corrective Action (b): The facility submitted a medical training curriculum from the PREA Resource Center which confirms it includes all required elements of subsection (b) of the standard; however, training records for 18 medical employees confirmed medical staff did not receive the training curriculum from the PREA Resource Center or any other training which includes the required elements of subsection (b) of the standard. The facility submitted training certificates for two medical staff which confirm the two medical staff received annual PREA training; however, the standard requires all medical staff receive specialized training to include how to detect and assess signs of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, how to preserve physical evidence of sexual abuse, and how and to whom to report allegations or suspicions of sexual abuse/harassment. The facility resubmitted eight staff training transcripts; however, the additional staff training transcripts did not confirm medical staff received the required training. The facility submitted a memorandum to Auditor confirming the facility could not obtain any additional certificates from medical staff to confirm compliance with the standard. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (b) of the standard.

§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)(e)(f)(g): HCDC policy 3C-21(a) mandates, "All inmates are screened during intake, during the initial classification process, and at all subsequent classification reviews to assess their risk of being sexually abused by other inmates or sexually abusive toward other inmates. Employees must conduct this screening using a written screening instrument tailored to the gender of the population being screened." HCDC 3C-21(a) further states, "At a minimum, employees use the following criteria to screen male inmates for risk of victimization: mental or physical disability, young age, slight build, first incarceration in prison or jail, nonviolent history, prior convictions for sex offenses against an adult or child, sexual orientation of gay or bisexual, gender nonconformance (e.g., transgender or intersex identity), prior sexual victimization, and the inmate's own perception of vulnerability. At a minimum, employees use the following criteria to screen male inmates for risk of being sexually abusive: prior acts of sexual abuse/harassment and prior convictions for violent offenses. At a minimum, employees use the following criteria to screen female inmates for risk of sexual victimization: prior sexual victimization and the inmate's own perception of vulnerability. At a minimum, employees use the following criteria to screen female inmates for risk of being sexually abusive: prior acts of sexual abuse/harassment. Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to screening questions. The department shall implement appropriate controls on the dissemination within the facility of responses to questions asked to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates." A review of HCDC policy 3C-21(a) confirms it does not include whether the male detainee has a developmental disability, limits the screening to male detainees who are young or slight of build, or a history of prior institutional violence or sexual abuse, as known to the facility. In addition, a review of HCDC policy 3C-21(a) confirms when screening female detainees the facility does not take into consideration mental, physical, or developmental disability, the age of the detainee, the physical build and appearance of the detainee, whether the detainee has previously been incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, the detainee's own concerns about her physical safety, or prior convictions for violent offenses and a history of institutional violence or sexual abuse as known to the facility. A review of HCDC policy 3C-21(a) further confirms the policy does not require a reassessment for risk of sexual victimization upon receipt of additional information or following an incident of abuse or victimization or that the detainee be kept separate from the general population until he/she is classified and may be housed accordingly. During the on-site tour, and in interviews with booking staff, it was indicated during intake, detainees are assessed for the likelihood of being a sexual aggressor or sexual abuse victim. All detainees are held within the booking area until booking is completed. Interviews with booking staff further indicated the detainee is asked the questions from the initial PREA Assessment form; however, the Auditor reviewed a completed assessment form and confirmed it did not consider whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In an interview with the classification officer, it was indicated that a reassessment would be completed utilizing the same form as the initial assessment. In an interview with the classification officer and PSA Compliance Manager it was indicated the assessment is completed on the jail system which is called Spillman. The Spillman system grants system access based on defined job roles. The Classification officer and PSA Compliance Manager further indicated a detainee would not be disciplined for refusing to answer any questions on the assessment and that a reassessment would be completed after an incident of sexual abuse or when additional information was received that would warrant an assessment being completed. The Auditor reviewed six detainee files and confirmed initial classification and housing assignments were completed within 12 hours of admission in all files. In addition, a review of the six detainee files confirmed two reassessments, although due, were not completed between 60 and 90 days as required by subsection (e) of the standard. A review of two investigation files indicated one

detainee was provided the required reassessment and the other was released prior to the required reassessment being conducted.

Does Not Meet (c)(e): The facility is not in compliance with subsections (c) and (e) of this standard. The Auditor reviewed a provided completed assessment form and confirmed it did not include the facility considered whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In addition, the Auditor reviewed six detainee files and confirmed two of the files, although due, did not include a reassessment for risk of sexual abuse or sexual aggression between 60 and 90 days as required by subsection (e) or the standard. The Auditor reviewed two sexual abuse allegation investigation files and confirmed only one file included the reassessment after an incident of sexual abuse as required by the standard. To become compliant, the facility must implement a practice that requires the facility to consider whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. The facility must train all applicable staff on the new practice and document such training. The facility must provide the Auditor with 10 detainee files to confirm that the facility Initial PREA Assessment form/process has been updated. In addition, the facility must implement a practice that ensures all detainees are reassessed for risk of abusiveness or victimization between 60-90 days of the initial assessment and after an incident of sexual abuse. Once implemented the facility must provide documentation that all classification staff are trained on the new practice. If applicable, the facility must provide the Auditor with 10 detainee files that include reassessments of detainee's risk of victimization and abusiveness, between 60-and-90 days of the initial assessment. The facility must submit to the Auditor all sexual abuse investigation files that occurred during the CAP period and the corresponding reassessment.

Corrective Action (c)(e): The facility submitted an updated initial risk assessment form which confirms the facility considers whether the detainee has a physical disability, whether the detainee identifies as gay, bi-sexual, transgender, intersex, or gender nonconforming and the detainee's concerns about his/her safety. The Auditor reviewed the updated initial reassessment form and no longer requires the facility to submit an additional nine detainee files to confirm compliance. The facility submitted five detainee initial risk assessments and reassessments which confirm the reassessment occurred between 60 and 90 days of the initial risk assessment. As the facility submitted documentation to confirm reassessments are being conducted within in the timeframes required by the standard the Auditor no longer requires the facility to submit documentation to confirm all classification staff have been trained on the standards requirement to reassess a detainee's risk of victimization and abusiveness between 60-and-90 days of the initial assessment. The facility submitted a memorandum to Auditor which confirms there has not been any sexual abuse allegation investigations that have occurred during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (c) and (e) of the standard.

§115. 42 - Use of assessment information

Outcome: Does not Meet Standard

Notes:

(a)(b)(c): HCDC policy 3C-21(a) mandates, "Employees use information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. The facility makes individualized determinations about how to ensure the safety of each inmate. Lesbian, gay, bisexual, transgender, or other gender-nonconforming inmates are not placed in particular facilities, units, or wings solely on the basis of their sexual orientation, genital status, or gender identity. Inmates at high risk for sexual victimization may be placed in segregated housing only as a last resort and then only until an alternative means of separation from likely abusers can be arranged. To the extent possible, risk of sexual victimization should not limit access to programs, education, and work opportunities." In interviews with the PSA Compliance Manager and Classification Supervisor it was indicated that information obtained from the assessment would be utilized to ensure the safety and wellbeing of the detainee; however, a review of the facility Initial PREA Assessment form confirms it does not consider whether the detainee has a physical disability, whether the detainee identifies as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In addition, interviews with booking staff indicated that should the assessment identify a victim or abuser a referral would be made to medical or mental health as appropriate; however, the assessment does not include whether the detainee identifies as transgender, intersex or gender nonconforming or the detainee's own concerns about his/her safety. In an interview with the Classification Supervisor, it was further confirmed that reassessments would be completed two times a year to evaluate safety concerns utilizing the Initial PREA Assessment form. In interviews with five random detention deputies, it was indicated should a transgender detainee want to shower separately from other detainees the opportunity exists. The facility did not provide documentation to confirm that the facility Initial PREA Assessment form was utilized to make decisions regarding a detainee's initial housing, recreation or other activities, and voluntary work. There were no transgender or intersex detainees housed at the facility during the on-site audit.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. A review of the facility Initial PREA Assessment form confirms it does not consider whether the detainee has a physical disability, whether

the detainee identifies as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In addition, the facility did not provide documentation to confirm that the facility Initial PREA Assessment form was utilized to make decisions regarding a detainee's initial housing, recreation or other activities, and voluntary work. In interviews with booking staff, it was indicated that should the assessment identify a victim or abuser a referral would be made to medical or mental health as appropriate; however, the assessment does not include whether the detainee identifies as transgender, intersex or gender nonconforming or the detainee's own concerns about his/her safety. To become compliant, the facility must implement a practice that requires the facility to consider whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. Once implemented, the facility must train all applicable staff on the new practice and document such training. In addition, the facility must establish and implement a procedure to ensure that information gained from the initial risk screening is considered when determining detainee housing, recreation and other activities, and voluntary programming and that medical and/or mental health staff are consulted when determining placement for transgender and intersex detainees. Once implemented, the facility must submit documentation that all applicable staff, including medical and mental health, are trained on the new procedure. In addition, the facility must submit 10 detainee files to confirm information gained from the initial risk assessment was considered in determining the detainee's housing, recreation and other activities, and voluntary work program. If applicable, the facility must submit to the Auditor all detainee files that include transgender or intersex detainees that were received during the CAP period.

Corrective Action (a)(b): The facility submitted an email with read receipts which confirms staff have received training on the standard's requirements information from the initial risk assessment is to be used to determine housing, recreation and other activities, and voluntary programming and medical and/or mental health staff are to be consulted when determining placement for transgender and intersex detainees. The facility submitted one updated risk assessment which confirms the updated risk assessment considers whether the detainee has a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, and the detainee's own concerns about his/her safety; however, the submitted initial risk assessment does not confirm information gained from the initial risk assessment was used to inform detainee assignments to housing, recreation and other activities, and volunteer programming. The facility submitted a memorandum to Auditor stating there have not been any transgender or intersex detainees housed at HCDC during the CAP period. Upon review of all submitted documentation, or lack thereof, the Auditor now finds the facility in substantial compliance with subsection (b) of the standard; however, continues to find the facility does not meet subsection (a).

§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)(d)(e): HCDC policy 3C-36, Special Management Units, mandates, "An inmate will be placed in "protective custody" status in Administrative Segregation only when there is documentation that it is warranted and that no reasonable alternatives are available" and "a member of Classification shall conduct a review within 72 hours of the inmate's placement in Administrative Segregation to determine whether segregation is still warranted. The review shall include an interview with the inmate. A written record shall be made of the decision and the justification." HDCD policy 3C-36 further states, "Generally, these inmates shall receive the same privileges as are available to inmates in the general population, depending on any safety and security considerations for inmates, facility staff and security." In addition, HCDC policy 3C-36 states, "Immigration Customs Enforcement (ICE Field Operating Director (FOD) will be contacted within 72 hours of placement in Administrative Segregation" and "a member of Classification shall conduct the same type of review after the inmate has spent 7 days in Administrative Segregation, and every week thereafter, for the first 60 days and (at least) every 30 days thereafter." A review of HCDC policy 3C-36 confirms it does not include the requirements to place detainees in Administrative Segregation for the least amount of time practicable and that such placement shall not ordinarily exceed 30 days. In addition, a review of HCDC policy 3C-36 confirms it does not require a supervisor to conduct a review within 72 hours of the detainee's placement in Administrative Segregation or after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter. The Auditor reviewed HCDC policy 3C-36 and could not confirm that the facility had developed the procedures in consultation with the ICE ERO FOD. The Auditor reviewed a blank Administrative/Disciplinary Segregation Placement/Review Form and confirmed the form has a line for a member of the assigning supervisor to sign and an area to mark "protective custody" as the reason for placement in administrative segregation; however, the form does not include an area to document that the detainee is being placed in Administrative Segregation on the basis of being vulnerable to sexual abuse or assault. A review of the Administrative/Disciplinary Segregation Placement/Review Form further confirmed it does not include documentation that confirms the appropriate ICE FOD was notified no later than 72 hours after the initial placement into segregation was made or that the required reviews were conducted by a supervisor. In an interview with the PSA Compliance Manager and OIC it was indicated that detainees would be held in administrative segregation for the least amount of time; however, the PSA Compliance Manager could not articulate the timeframes required by the standard.

Does Not Meet (a)(b)(d)(e): The facility is not in compliance with subsections (a), (b), (d), and (e) of the standard. A review of HCDC policy 3C-36 confirms it does not include the requirements to place detainees in Administrative Segregation for the least amount of time practicable and that such placement shall not ordinarily exceed 30 days. In addition, a review of HCDC policy 3C-36 confirms it does not require a supervisor to conduct a review within 72 hours of the detainee's placement in Administrative Segregation or after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter. The Auditor reviewed HCDC policy 3C-36 and could not confirm that the facility had developed the procedures in consultation with the ICE ERO FOD. The Auditor reviewed a blank Administrative/Disciplinary Segregation Placement/Review Form and confirmed the form has a line for a member of the assigning supervisor to sign and an area to mark "protective custody" as the reason for placement in administrative segregation; however, the form does not include an area to document that the detainee is being placed in Administrative Segregation on the basis of being vulnerable to sexual abuse or assault. A review of the Administrative/Disciplinary Segregation Placement/Review Form further confirmed it does not include documentation that confirms the appropriate ICE FOD was notified no later than 72 hours after the initial placement into segregation was made or that the required reviews were conducted by a supervisor. To become compliant, the facility must, in consultation with the ERO FOD, update HCDC policy 3C-36 to include the requirements to place detainees in Administrative Segregation for the least amount of time practicable, that such placement shall not ordinarily exceed 30 days, and supervisory staff will conduct a review within 72 hours of a detainee's placement in administrative segregation, an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter. Once developed the facility must provide the Auditor with a copy of HCDC policy 3C-36 with documentation that the policy was updated in consultation with the ERO FOD. Once implemented the facility must train all security supervisors on the requirements of updated HCDC policy 3C-36 and provide the Auditor with documentation that confirms the training was received. If applicable, the facility must submit to the Auditor any detainee files that include a detainee being placed in protective custody due to being vulnerable to sexual abuse to confirm the reasons for placement were documented and that the ICE ERO FOD was notified within 72 hours of the initial placement in Administrative Segregation.

Corrective Action (a)(b)(d)(e): The facility submitted updated policy HCDC-3C-36 which confirms updated policy HCDC-36 requires when the facility places detainees in Administrative Segregation due to being vulnerable to sexual abuse the placement will be for the least amount of time practicable and shall not ordinarily exceed 30 days. A review of updated policy HCDC 3C-36 further confirms updated policy HCDC 36 requires a Classification Supervisor to conduct the same type of review after the inmate has spent 7 days in Administrative Segregation, and every week thereafter, for the first 60 days and (at least) every 10 days thereafter. The facility submitted an email from the ICE ERO FOD which confirms policy HCDC 3C-36 was updated in consultation with the ICE ERO FOD. The facility submitted an email with read receipt sent to all Classification staff which confirms all Classification staff have received training on updated policy HCDC 3C-36. The facility submitted a memorandum to Auditor which confirms there were no detainees placed in protective custody due to being vulnerable to sexual abuse during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), (d) and (e) of the standard.

§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)(c): HCDC policy 3C-21(a) mandates, "The facility provides multiple internal ways for inmates to-report easily, privately, and securely sexual abuse/harassment, retaliation by other inmates or staff for reporting sexual abuse/harassment, and staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse/harassment. The facility also provides at least one way for inmates to report the abuse/harassment to an outside public entity or office not affiliated with the agency that has agreed to receive reports and forward them to the facility head, except when an inmate requests confidentiality. Staff accepts reports made verbally, in writing, anonymously, and from third parties and immediately puts into writing any verbal reports." During the on-site tour the Auditor observed in housing units and the booking area the DHS-prescribed sexual abuse and assault awareness notice, the DHS-prescribed SAA Information pamphlet, the contact information for the DHS OIG and foreign consulate, in English and Spanish, and the HCDC zero-tolerance poster in English only. The Auditor reviewed the HCDC facility handbook and confirmed it did not list information on how a detainee could report retaliation or staff neglect or violations that may have contributed to such incidents or that detainees are allowed to report anonymously or specific instruction on avenues to report anonymously. A review of the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet confirms how to make an anonymous report of sexual abuse is included; however, the Auditor could not confirm that the ICE National Detainee Handbook or the DHS-prescribed SAA Information pamphlet is provided to all detainees in a manner they could understand. The Auditor was provided with a signed MOU with the Crisis Center of Grand Island and was able to confirm this organization would accept reports of sexual abuse; however, a review of the MOU further confirmed the Crisis Center of Grand Island would only release the victim's confidential information after receiving appropriate authorization from the victim thus hindering their abilities to immediately forward all reported allegations of sexual abuse or receive an anonymous report. During the on-site

tour, the Auditor attempted to place calls to the telephone number included in the DHS-prescribed sexual abuse and assault awareness notice, the National Sexual Assault Hotline, the DHS OIG, and the Crisis Center of Grand Island from the housing unit telephones utilizing a generic PIN that can be utilized for each housing unit to make anonymous reports; however, when the Auditor attempted to call numbers utilizing the PIN, a voice recording was received stating, "Cannot respond, goodbye" or "Denied for account." In interviews with the PSA Compliance Manager and five detention deputies it was confirmed that all reports of sexual abuse made by a detainee verbally, in writing, anonymously, and through third parties would be accepted and all reports made verbally would be documented.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. A review of the MOU with the Crisis Center of Grand Island confirmed the Crisis Center of Grand Island would only release the victim's confidential information after receiving appropriate authorization from the victim thus hindering their abilities to immediately forward all reported allegations of sexual abuse or accept an anonymous report. During the on-site audit, the Auditor attempted to place calls to the telephone numbers included in the DHS-prescribed sexual abuse and assault awareness notice, the National Sexual Assault Hotline, the DHS OIG, and the Crisis Center of Grand Island from the housing unit telephones utilizing a generic PIN that can be utilized for each housing unit to make anonymous reports; however, when the Auditor attempted to call numbers utilizing the PIN, a voice recording was received stating, "Cannot respond, goodbye" or "Denied or account." To become compliant, the facility must provide detainees at least one way to report an allegation to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request, including but not limited to, working telephones that enable a detainee to contact said outside entity. Once implemented, the facility must provide the Auditor with documentation that confirms the new procedure was implemented. In addition, the facility must provide documentation that facility telephones are in working order to allow detainees access to report an allegation of sexual abuse, retaliation for reporting an incident of sexual abuse, staff neglect, or violations of staff responsibilities that may have contributed to an incident to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request.

Corrective Action (b): The facility submitted a memorandum confirming test calls were completed to the DHS OIG. In addition, the facility submitted emails between the PSA Compliance Manager and SILO tech support (CIDNET telephone system) which confirm calls can be made utilizing a universal PIN, are not recorded, and are free to the detainees. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (b) of the standard.

§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): HCDC policy 51-02, Grievance Procedure, mandates, "Grievances involving immediate threats to the safety and/or security of an inmate shall be immediately expedited to the Shift Supervisor or designee for investigation. Inmates are not required to utilize any informal grievance process or to otherwise attempt to resolve with staff, an alleged incident of sexual assault/abuse. Initial responses to sexual assault/abuse grievances including sexual assault/abuse will be given within 48 hours with a completed final decision within 5 calendar days. The response will document the determination of whether the inmate is in substantial risk of immediate sexual abuse and the action taken in response to the grievance." HCDC policy 51-02 further states, "The final agency decision regarding the merits of any portion of the grievance alleging sexual abuse will be issued within 90 days of the initial filing of the grievance. Third party, fellow inmates, staff members, family members, attorneys and outside advocates may submit a grievance alleging sexual abuse on behalf of an inmate. The department may discipline an inmate for filing a grievance related to alleged sexual abuse only when the department demonstrates that the inmate filed the grievance in bad faith" and "no time lime limitations are placed on grievances alleging sexual abuse." In addition, HCDC policy 51-02 states, "Inmates may appeal their grievance response to the Assistant Director of Corrections within seventy-two hours of receiving their response." The Auditor reviewed HCDC policy 51-02 and confirmed it does not include the requirements to issue a decision on the grievance within five days of receipt or the facility shall respond to an appeal of a grievance related to sexual abuse within 30 days. HCDC policy 6B-05, Procedure in the Event of a Sexual Assault, mandates, "Any inmate that alleges he/she was a victim of a sexual assault will be immediately removed from their current housing location and taken to the medical area. The medical staff will treat any injuries requiring immediate attention but will not perform any routine examination procedures." HCDC Inmate/Detainee Handbook states in part "Inmates/detainees may request assistance from another inmate/detainee or staff member to assist them with the grievance process, the Department's response to a grievance will be returned in a timely manner and detainees may appeal a grievance to ICE. In interviews with the PSA Compliance Officer and Grievance Officer (GO) it could not be confirmed the facility sends all grievances related to sexual abuse and the facility decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. In an interview with the GO, it was indicated detainees are permitted to file a formal grievance related to sexual abuse at any time with no time limit imposed and that there are written procedures for handling time-sensitive grievances. In addition, the GO indicated medical emergencies are brought to the immediate attention of medical staff, decisions are issued on sexual abuse incidents within

five days of receipt, and the facility OIC responds to an appeal of said grievances within 30 days. In an interview with the GO, it was further indicated that all grievances are sent through the CIDNET system and received almost instantaneously. In an interview with the PSA Compliance Manager, it was confirmed that HCDC does not impose a time limit for grievances related to sexual abuse. In interviews with five detention deputies and the GO it was indicated that medical grievances will be processed immediately and that should a detainee require the assistance of a third party to complete the grievance, one will be accommodated.

Does Not Meet (e)(f): The facility is not in compliance with subsections (e) and (f) of the standard. The Auditor reviewed HCDC policy 51-02 and confirmed it does not include the requirements to issue a decision on the grievance within five days of receipt or the facility shall respond to an appeal of a grievance related to sexual abuse within 30 days. In interviews with the PSA Compliance Officer and GO it could not be confirmed the facility sends all grievances related to sexual abuse and the facility decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. To become compliant, the facility must implement practices that requires the facility to issue a decision on a grievance related to sexual abuse within five days of receipt, to respond to an appeal of a grievance related to sexual abuse within 30 days, and to send all grievances related to sexual abuse and the facility decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. Once implemented the facility must document that all applicable staff have been trained on the new practices. If applicable, the facility is to submit to the Auditor copies of any time sensitive grievances that involve an immediate threat to detainee health, safety or welfare and related to sexual abuse occurring during the CAP period.

Corrective Action (e)(f): The facility submitted updated policy HCDC-51-02 which confirms the Assistant Director will give a response to an inmate detainee within 30 days of receiving a grievance appeal and will forward the decision to the ICE Field Office Director. A review of updated policy HCDC-51-02 further confirms HCDC-51-02 requires staff to send all grievances related to sexual abuse and the facility decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (e) and (f) of the standard.

§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): HCDC policy 3C-21(a) mandates, "In addition to providing on-site mental health care services, the facility provides inmates with access to outside victim advocates for emotional support services related to sexual abuse/harassment. The facility provides such access by giving inmates the current mailing addresses and telephone numbers, including toll-free hotline numbers, of local, State, and/or national victim advocacy or rape crisis organizations and enabling reasonable communication between inmates and these organizations. The facility ensures that communications with such advocates are private, confidential, and privileged, to the extent allowable by Federal, State, and local law." HCDC policy 3C-21(a) further states, "The facility informs inmates, prior to giving them access, of the extent to which such communications will be private, confidential, and/or privileged. The Auditor reviewed a MOU between the facility and Crisis Center of Grand Island and confirmed the Crisis Center of Grand Island would provide confidential emotional support services and crisis intervention; however, the verbiage in the MOU does not confirm the Crisis Center of Grand Island would provide investigation and the prosecution of sexual abuse perpetrators to most appropriately address victims' needs. During the on-site audit the Auditor observed the HDCD zero-tolerance poster and confirmed it included the contact information for the Crisis Center of Grand Island; however, the poster did not include the extent to which the detainee phone calls to the center would be monitored or the extent to which reports of abuse would be forwarded to the authorities in accordance with mandatory reporting laws. In addition, the Auditor reviewed the facility handbook and confirmed it advises the detainee the extent to which phone calls would be monitored; however, it does not advise the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. During the on-site tour the Auditor observed the HDCD zero-tolerance poster and confirmed it included the contact information for the Crisis Center of Grand Island; however, the poster did not include the extent to which the detainee phone call to the center would be monitored or the extent to which reports of abuse would be forwarded to the authorities in accordance with mandatory reporting laws. In addition, the Auditor reviewed the facility handbook and confirmed it advises the detainee the extent to which phone calls would be monitored; however, it does not advise the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. To become compliant, the facility must provide to the Auditor documentation that the facility notified the detainee population the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory laws in a manner that all detainees could understand, including but not limited to, those detainees who speak a language other than English or Spanish.

Corrective Action (d): The facility submitted updated Booking policy HCDC-4A-08 which confirms staff will translate all PREA information to every detainee in a language/manner they can understand to include the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory laws. The facility submitted an email to all staff with read receipts which confirms staff have received training on the standard's requirement to advise detainees the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory laws. The facility submitted five signed detainee acknowledgements and one unsigned which confirm an interpreter was utilized. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of 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)(b): HCDC policy 3C-21(a) mandates, "Upon learning that an inmate was sexually abused within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report is required to separate the alleged victim and abuser; seal and preserve any crime scene(s); instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder non-security staff member, he or she is required to instruct the victim not to take any actions that could destroy physical evidence and then notify security staff." Interviews with five detention deputies, booking, and classification staff confirmed that they were knowledgeable regarding their duties as a first responder with the exception of the standard's requirement to request the victim not take actions and ensure the alleged abuser does not take actions to destroy evidence.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. A review of HCDC policy 3C-21(a) requires security first responders and non-security first responders instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. In addition, a review of HCDC policy 3C-21(a) confirms it does not include the requirement that security first responders ensure the alleged abuser does not take actions to destroy evidence. In interviews with five detention deputies, booking, and classification staff indicated they could not articulate the standards requirement to request the victim not take actions and ensure the alleged abuser does not take actions to destroy evidence. To become compliant, the facility must update HCDC policy 3C-21 to include the requirements that security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating and to ensure the alleged abuser does not take actions to destroy evidence. In addition, the facility must update HCDC policy 3C-21(a) to include the requirement that non-security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. Once updated the facility must train all security first responders and non-security first responders on the updated policy. If applicable the facility must submit to the Auditor all sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action (a): The facility submitted updated policy HCDC 3C-21 which confirms updated policy HCDC 3C-21 requires security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating and to ensure the alleged abuser does not take actions to destroy evidence and non-security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. The facility submitted an email and read receipts which confirm both security and non-security first responders have received training on their responsibilities as first responders. The facility submitted a memorandum to Auditor which confirms there has not been any sexual abuse allegation investigations that have occurred during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

§115. 65 - Coordinated response

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(d): The facility submitted HCDC policy 3C-21(a) as their Coordinated Response Plan. HCDC policy 3C-21(a) mandates, "Upon learning that an inmate was sexually abused within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report is required to separate the alleged victim and abuser; seal and preserve any crime scene(s); instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder non-security staff member, he or she is required to instruct the victim not to take any actions that could destroy physical evidence and then notify security staff. All actions taken in response to.an incident of sexual abuse/harassment are coordinated among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The facility's coordinated response ensures that victims receive all necessary immediate

and ongoing medical, mental health, and support services and that investigators are able to obtain usable evidence to substantiate allegations and hold perpetrators accountable." A review of HCDC policy 3C-21(a) confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. In addition, a review of HCDC policy 3C-21(a) confirms it requires security first responders and non-security first responders instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. In interviews with five detention deputies, booking and classification staff it was indicated they could not articulate the requirement to request the detainee victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. A review of HDCD policy 3C-21(a) further confirms it does not include the required verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The Auditor reviewed two allegations of sexual abuse investigation allegations and confirmed neither included a detainee who was transferred due to an incident of sexual abuse.

Does Not Meet (a)(c)(d): The facility is not in compliance with subsections (a), (c) and (d) of the standard. A review of HCDC policy 3C-21(a), which serves as the facility's coordinated response plan, confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. In addition, a review of HCDC 3C-21(a) confirms it requires security first responders and non-security first responders instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. A review of HDCD policy 3C-21(a) further confirms it does not include the required verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." In interviews with five detention deputies, booking, and classification staff it was indicated they could not articulate the requirement to request the detainee victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. To become compliant, the facility must update HCDC policy 3C-21(a) to include the coordinated actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse, and to include the requirements security first responders to request detainee the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating and to ensure the alleged abuser does not take actions to destroy evidence and non-security first responders request detainee the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. In addition, the facility must update HCDC policy 3C-21(a) to include the verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." Once implemented the facility must document that all applicable staff, including medical, have been trained on the updated procedure. If applicable, the facility must submit all sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action (a)(c)(d): The facility submitted updated policy HCDC-3C-21 which serves as the facility coordinated response plan. The Auditor reviewed updated policy HCDC-3C-21 and confirmed it includes the verbiage, "All actions taken in response to an incident of sexual abuse/harassment are coordinated among staff first responders, medical and mental health practitioners, investigators, and facility leadership; however, the standard requires the coordinated response plan coordinates the actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. A review of updated policy HCDC-3C-21 further confirms updated HCDC policy 3C-21 includes the requirements security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating and to ensure the alleged abuser does not take actions to destroy evidence and non-security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. In addition, a review of updated policy HCDC-3C-21 confirms it requires "If a victim of sexual abuse is transferred between facilities, the sending

facility shall as be permitted by law inform the receiving facility of the incident and the victim's potential need for medical or other social services" and "if a victim of sexual abuse is transferred from a DHS immigration detention facility to a non-DHS immigration detention facility, the sending facility shall as permitted by law inform the receiving facility of the incident and the victim's potential need for medical or other social services, unless victim requests otherwise; however, the standard requires the coordinated response plan to include the requirements "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The facility submitted an email and read receipts confirming a medical staff person had reviewed updated policy HCDC-3C-21 (a); however, updated policy HCDC-3C-21 (a) does not include the requirements of subsections (c) and (d) of the standard nor does it serve as the facility coordinated response plan. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsections (a), (c), and (d) of the standard.

§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): Agency policy 11062.2 mandates, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." HCDC 3C-21(a) mandates, "The agency protects all inmates and staff who report sexual abuse/harassment or cooperate with sexual abuse/harassment investigations from retaliation by other inmates or staff. The agency employs multiple protection measures, including 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/harassment or cooperating with investigations. The agency monitors the conduct and/or treatment of inmates or staff who have reported sexual abuse/harassment or cooperated with investigations, including any staff reassignments, negative staff performance reviews, inmate disciplinary reports, housing, or program changes, for at least 90 days (or longer if needed) following their report or cooperation to see if there are changes that may suggest possible retaliation by inmates or staff. The agency discusses any changes with the appropriate inmate or staff member as part of its efforts to determine if retaliation is taking place and, when confirmed, immediately takes steps to protect the inmate or staff member. Monitoring shall include periodic welfare checks. This is monitored by the PREA Coordinator." In an interview with the PSA Compliance Manager, it was indicated detainees do not program at HCDC; however, they would be monitored to include housing and disciplinary reports. The Auditor reviewed two sexual abuse allegation investigation files and confirmed there was no documentation to confirm either detainee was monitored following their report of sexual abuse.

Does Not Meet (c): The facility is not in compliance with subsection (c) of this standard. Although there were two allegations reported during the audit period, the facility did not submit any documentation that confirmed retaliation monitoring was conducted for either case. To become compliant, the facility must provide documentation that confirms retaliation monitoring was conducted for both detainees who reported an incident of sexual abuse. If documentation does not exist, the facility must provide documentation that staff responsible for detainee and staff monitoring following an incident of sexual abuse have been trained on the standards requirements. If applicable, the facility must provide the Auditor with all sexual abuse allegation investigation files and the corresponding monitoring documentation the occurred during the CAP period.

Corrective Action (c): The facility submitted updated policy HCDC-3C-22 which confirms updated policy HCDC-3C-22 requires the PREA Coordinator monitor all allegations of sexual abuse to include cases determined to be both founded and unfounded. The facility submitted updated HCDC 3C-21(a) which requires staff, contractors, volunteers, and detainees not retaliate against any detainees and/or staff who report sexual abuse/harassment or cooperates with a sexual abuse/harassment investigation. A review of updated HCDC policy 3C-21 (a) further confirms it requires the Agency employ multiple protection measures, including housing changes or transfers for detainee victims of sexual abuse, removal of alleged staff or detainee sexual abuse perpetrators from contact with detainee victims of sexual abuse, and emotional support services for detainee victims of sexual abuse or staff who fear retaliation for reporting sexual abuse/harassment or cooperating with investigations. In addition, a review of updated HCDC policy 3C-21 (a) confirms updated HCDC policy 3C-21 (a) requires the Agency monitor the conduct and/or treatment of detainees or staff who have reported sexual abuse/harassment or cooperated with investigations, including any staff reassignments, negative staff performance reviews, detainee disciplinary reports, housing, or program changes, for at least 90 days (or longer if needed) following their report of sexual abuse or cooperation with an investigation of sexual abuse to evaluate any changes which may suggest possible retaliation by detainees or staff. A review of updated HCDC policy 3C-21 (a) further confirms updated HCDC policy 3C-21 (a) requires the Agency discuss any changes with the affected detainee or staff member as part of its efforts to determine if

retaliation is taking place and, when confirmed, immediately take steps to protect the detainee or staff member to include periodic welfare checks. The facility submitted a memorandum to Auditor which confirms there has not been any allegations of sexual abuse during the CAP period. The Auditor reviewed the memorandum and accepted there have been no sexual abuse allegation investigation files that occurred since the implementation of the new procedure; and therefore, the Auditor no longer requires the facility to submit documentation to confirm retaliation monitoring was conducted for both detainees who reported an incident of sexual abuse during the audit period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (c) of the standard.

§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): HCDC policy 3C-21(a) mandates, "Agency investigations into allegations of sexual abuse/harassment are prompt, thorough, objective, and conducted by investigators who have received special training in sexual abuse/harassment investigations. When outside agencies investigate sexual abuse/harassment, the facility has a duty to keep abreast of the investigation and cooperate with outside investigators. Investigations include the following element: Investigations are initiated and completed within the timeframes established by the highest-ranking facility official, and the highest-ranking official approves the final investigative report. Investigators gather direct and circumstantial evidence, including any available physical and DNA evidence and any electronic monitoring data; interview alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse/harassment involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, prosecutors are contacted to determine whether compelled interviews may be an obstacle for subsequent criminal prosecution. Investigative findings are based on an analysis of the evidence gathered and a determination of its probative value. The credibility of a victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as inmate or staff. The Department will not allow the inmate to submit to a polygraph examination. Investigations include an effort to determine whether staff negligence or collusion enabled the abuse/harassment to occur. Administrative investigations are documented in written reports that include a description of the physical and testimonial evidence and the reasoning behind credibility assessments. Criminal investigations are documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and provides a proposed list of exhibits. The Department retains all written reports as long as the alleged abuser is incarcerated or employed by Department plus five years. Copies of all documentary evidence will be given to criminal investigators when feasible. Substantiated allegations of conduct that appears to be criminal are referred for prosecution." A review of HCDC policy 3C-21 and an interview with the facility SDDO confirmed HCDC policy 3C-21 was reviewed and approved by the Agency. A review of HCDC policy 3C-21 confirms it does not include the verbiage "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." In addition, a review of HCDC policy 3C-21(a) confirms it does not govern the coordination and sequencing of the two types of investigations in accordance with subsection (b) of the standard to ensure that the criminal investigation is not compromised by the internal administrative investigation or to continue the investigation should the alleged abuser or detainee victim depart from the employment or control of the facility. In an interview with a facility Investigator, it was indicated that the investigation would continue even if the alleged abuser or victim was no longer at the facility. The facility Investigator further indicated that should an outside agency investigate the case; evidence would be provided to support the case and he would remain in contact through emails or telephone calls regarding the status of the case. The Auditor was provided with certificates of completion from the National Institute of Corrections for the course: PREA: Investigating Sexual Abuse in a Confinement Setting for all facility Investigators. The Auditor reviewed the training curriculum and confirmed it included all elements required by the standard. The Auditor reviewed two sexual abuse allegation investigation files and confirmed the investigations were completed promptly, thoroughly, and objectively.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. A review of HCDC policy 3C-21(a) confirms it does not include the verbiage "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate or administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." In addition, a review of HCDC policy 3C-21(a) confirms it does not govern the coordination and sequencing of the two types of investigations in accordance with subsection (b) of the standard to ensure that the criminal investigation is not compromised by the internal administrative investigation or to continue the investigation should the alleged abuser or detainee victim depart from the employment or control of the facility. To become compliant, the facility must update HCDC policy 3C-21(a) to include the verbiage "Upon conclusion of a criminal investigation where the allegation was Substantiated, an

administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate and administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." In addition, the facility must update HCDC policy 3C-21(a) to govern the coordination and sequencing of the two types of investigations in accordance with subsection (b) of the standard to ensure that the criminal investigation is not compromised by the internal administrative investigation or to continue the investigation should the alleged abuser or detainee victim depart from the employment or control of the facility. Once updated the facility must resubmit HCDC policy 3C-21(a) to the Agency for review and approval. In addition, the facility must train all applicable staff, including all facility Investigators, on the updated written procedures. If applicable, the facility must submit to the Auditor all sexual abuse allegation investigation files that occurred during the CAP period.

Corrective Action (b)(c): The facility submitted updated policy HCDC-3C-21(a) which confirms it includes the verbiage, "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted" and "upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate and administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." A review of updated HCDC-3C-21 further confirms it includes the standard's requirements the coordination and sequencing of the criminal and administrative investigations will not be compromised by the internal administrative investigation and to continue the investigation should the alleged abuser or detainee victim depart from the employment or control of the facility. The facility submitted an email with read receipts to applicable staff, including facility Investigators, which confirms all applicable staff have received training on updated policy HCDC-3C-21(a). The facility submitted an email from the AFOD which confirms updated policy HCDC-3C-21(a) has been reviewed and approved by the Agency. The facility submitted a memorandum to Auditor which confirms there has not been any sexual abuse allegations reported during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (b) and (c) of the standard.

§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): HCDC policy 3C-21(a) mandates, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." Further review of HCDC policy 3C-21(a) confirms it does not require that the facility make reasonable efforts to report to any relevant licensing body, to the extend known, incidents of substantiated abuse by a contractor or volunteer. In an interview with the OIC it was confirmed that contractors or volunteers would have their security clearance revoked and not allowed to enter the facility; however, the interview could not confirm the facility would make reasonable efforts to report to any relevant licensing body, to the extend known, an incident of substantiated abuse by a contractor or volunteer.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of HCDC policy 3C-21(a) confirms it does not require that the facility make reasonable efforts to report to any relevant licensing body, to the extend known, incidents of substantiated abuse by a contractor or volunteer. In an interview with the OIC, it was confirmed that contractors or volunteers would have their security clearance revoked and not allowed to enter the facility; however, the interview could not confirm the facility make reasonable efforts to report to any relevant licensing body, to the extend known, an incident of substantiated abuse by a contractor or volunteer. To become compliant, the facility must implement a practice the requires the facility make reasonable efforts to report to any relevant licensing body, to the extent known, an incident of substantiated abuse by a contractor or volunteer. In addition, the facility must train all applicable staff on the updated practice. If applicable, the facility must submit all sexual abuse allegation investigation files that occurred during the CAP period that include facility volunteers or contractors.

Corrective Action (a): The facility submitted updated policy HCDC-3C-21(a) which confirms updated policy HCDC-3C-21(a) includes the standard's requirement the facility makes reasonable efforts to report to any relevant licensing body, to the extent known, an incident of substantiated abuse by a contractor or volunteer. The facility submitted an email to staff with read receipts which confirms all applicable staff have received training on updated policy HCDC-3C-21(a). The facility submitted a memorandum to Auditor which confirms there have not been any allegations of sexual abuse reported during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

§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): HCDC policy 3C-21(a) mandates, "Qualified medical or mental health practitioners ask inmates about prior sexual victimization and abusiveness during medical and mental health reception and intake screenings. If an inmate discloses prior sexual victimization or abusiveness, whether it occurred in an institutional setting or in the community, during a medical or mental health reception or intake screening, the practitioner provides the appropriate referral for treatment, based on his or her professional judgment. Any necessary referrals and/or follow up meetings shall be done within 14 days." In an interview with a facility RN it was confirmed the facility's two staff positions for mental health workers were not filled at the time of the on-site audit and if a mental health referral was needed medical would send the referral via email to be processed when a mental health worker was at the facility.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. A review of HCDC policy 3C-21(a) confirms that should information become known that the detainee has experienced prior sexual victimization or perpetrated sexual abuse staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow up and that such referrals and follow ups will be done within 14 days. Subsections (b) and (c) require a medical follow-up within 48 hours of the referral and a mental health follow-up within 72 hours of the referral. To become compliant, the facility must develop and implement a practice that requires all detainees referred to medical be seen within 48 hours of the referral and if referred to mental health be seen within 72 hours of the referral as required by subsection (c) of the standard. Once implemented, the facility must submit documentation that all medical and mental health staff have been trained on the new practice. If applicable, the facility must submit to the Auditor any intake, medical, and mental health records of any detainee, who pursuant to §115.41 indicates they have experienced prior sexual victimization or perpetrated sexual abuse during the CAP period.

Corrective Action (b)(c): The facility submitted updated policy HCDC-3C-21(a) which confirms HCDC-3C-21(a) requires when a detainee alerts any staff member of prior victimization then they will be referred immediately to Medical/Mental Health and a follow-up will be conducted within 48 hours. The facility submitted an email to all medical staff with read receipts which confirms all applicable staff have received training on updated policy HCDC-3C-21(a). The facility submitted an email with Willow Rising, Inc. (formerly the Crisis Center) confirming, if required, mental health services could be provided within 48 hours. The facility submitted a memorandum to Auditor which confirms there have not been any detainees received at the facility who has experienced prior sexual victimization during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (b) and (c) of the standard.

§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): HCDC policy 3C-21(a) mandates, "Victims of sexual abuse have timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. Treatment services must be provided free of charge to the victim and regardless of whether the victim names the abuser. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders take preliminary steps to protect the victim and immediately notify the appropriate medical and mental health practitioners." A review of HCDC policy 3C-21 confirms it does not include the requirements to provide emergency contraception or to provide sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. In an interview with a facility RN, it was indicated any detainee alleging sexual abuse and in need of emergency care would be taken to (CHI) Health St. Francis. The Auditor reviewed a signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed the detainee would be provided immediate medical care; however, the MOU does not confirm that (CHI) St. Francis would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, the Auditor reviewed a MOU with the Crisis Center of Grand Island and confirmed the Crisis Center has agreed to provide crisis intervention services to detainee victims of sexual abuse. In interviews with the PSA Compliance Manager, five detention deputies, and two custody first responders it was indicated medical treatment would be immediate for any detainee victim of sexual abuse. In addition, the PSA Compliance Manager indicated that medical services would be timely and free of charge; however, no documentation was received to confirm the services would be provided immediately and free of charge. During the on-site audit, The Auditor reviewed two sexual abuse allegation investigation files and confirmed a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of HCDC policy 3C-21 confirms it does not include the requirements to provide emergency contraception or to provide sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The Auditor reviewed of a

signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed the detainee would be provided immediate medical care; however, the MOU does not confirm that the care would include (CHI) Health St. Francis would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. During the on-site audit, the Auditor reviewed two sexual abuse allegation investigation files and could only confirm a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse. To become compliant, the facility must provide documentation that confirms detainee victims of sexual abuse are provided with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The facility must provide documented training to all applicable staff regarding their responsibility to provide the detainee victim with all requirements of the standard. If applicable, the facility must provide the Auditor with any sexual abuse allegation investigative files that occurred during the CAP period.

Corrective Action (a)(b): The facility submitted a signed addendum to the original MOU with St. Francis Medical Center which confirms (CHI) Health Saint Francis will provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The facility submitted an email to medical staff with read receipts which confirms all applicable staff have received training on the standard's requirements to provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The facility submitted a memorandum to Auditor which confirms there has not been any allegations of sexual abuse reported during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

§115. 83 - Ongoing medical and mental health care for sexual abuse victims and abusers
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d)(e)(f)(g): HCDC policy 3C-21(a) mandates, "The facility provides ongoing medical and/or mental health evaluation and treatment to all known victims of sexual abuse. The evaluation and treatment of sexual abuse victims must include appropriate follow-up services, treatment plans, and, when necessary, referrals for continued care following their release from custody. The level of medical and mental health care provided to inmate victims must match the community level of care generally accepted by the medical and mental health professional communities. The facility conducts a mental health evaluation of all known abusers and provides treatment, as deemed necessary by qualified mental health practitioners." HCDC policy 3C-21 further mandates, "Inmate victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. If pregnancy results from the abuse, such victim shall receive timely and comprehensive information about lawful pregnancy-related medical services." In addition, HCDC policy 3C-21(a) mandates, "Treatment services must be provided free of charge to the victim and regardless of whether the victim names the abuser." A review of HCDC policy 3C-21(a) confirms it does not require the facility provide detainee victims of sexual abuse with a pregnancy test, timely and comprehensive information about lawful pregnancy-related medical services, timely and lawful pregnancy- related medical services, tests for sexually transmitted infections as medically appropriate, or treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The Auditor reviewed a signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed a detainee victim of sexual abuse would be provided immediate medical care; however, the MOU does not confirm that the care (CHI) St. Francis would provide detainee victims of sexual abuse with included emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In an interview with the PSA Compliance Manager, it was confirmed during the on-site audit there were two mental health positions that were not filled. In an interview with the facility RN, it could not be confirmed how the facility would provide the detainee with the mental health services required by subsections (a), (b), (c), and (g) of the standard. During the on-site audit, The Auditor reviewed two sexual abuse allegation investigation files and confirmed a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse.

Does Not Meet (a)(b)(c)(e)(f)(g): The facility is not in compliance with subsections (a), (b), (c), (e), (f), and (g) of the standard. A review of HCDC policy 3C-21(a) confirms it does not require the facility provide detainee victims of sexual abuse with a pregnancy test, timely and comprehensive information about lawful pregnancy-related medical services, timely and

lawful pregnancy-related medical services, tests for sexually transmitted infections as medically appropriate, or medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In an interview with the facility RN, it was indicated any detainee victim of sexual abuse in need of medical treatment would be taken to (CHI) Health St. Francis. The Auditor reviewed a signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed a detainee victim of sexual abuse would be provided immediate medical care; however, the MOU does not confirm that the care (CHI) St. Francis would provide detainee victims of sexual abuse with included a pregnancy test, timely and comprehensive information about lawful pregnancy-related medical services, timely and lawful pregnancy-related medical services, tests for sexually transmitted infections as medically appropriate, or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse, emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In an interview with the PSA Compliance Manager, it was confirmed during the on-site audit there were two mental health positions that were not filled. In an interview with the facility RN, it could not be confirmed how the facility would provide the detainee with the mental health services required by subsections (a), (b), (c), and (g) of the standard. The Auditor reviewed two sexual abuse allegation investigation files and confirmed a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse. To become compliant, the facility must provide documentation that confirms detainee victims of sexual abuse are provided with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, the facility must provide documentation that confirms mental health staff are available to provide the detainee victim of sexual abuse with all required elements of subsections (a), (b), (c), (e), (f), and (g) of the standard. The facility must provide documented training of all applicable staff, including medical and mental health, regarding their responsibility to provide the detainee victims of sexual abuse with all requirements of the standard. If applicable, the facility must provide the Auditor with any sexual abuse allegation investigative files that occurred during the CAP period. If applicable, the facility must provide the detainee files, including medical and mental health of any known detainee-on-detainee abusers housed at HCDC during the CAP period.

Corrective Action (a)(b)(c)(e)(f)(g): The facility submitted updated policy HCDC-3C-21 (a). A review of updated policy HCDC-3C-21(a) confirms although it requires a mental health evaluation of all known abusers and provides treatment, as deemed necessary by qualified mental health practitioners, it does not require mental health staff attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days as required by the standard. The facility submitted updated HCDC-3C-21(a) Prison Rape Elimination Act (PREA) policy, email to medical staff and read receipts indicating staff have read the updated policy; however, updated policy HCDC-3C-21(a) Prison Rape Elimination Act (PREA) does not require a mental health evaluation of all known detainee-on-detainee abusers be attempted to be conducted within 60 days as required by the standard. The facility submitted an email with Willow Rising, Inc. (formerly the Crisis Center) confirming Willow Rising, Inc., if required, are available to provide the detainee victim of sexual abuse with all required elements of subsections (a), (b), (c), (e), and (f) of the standard. The facility submitted a signed addendum to an existing MOU between HCDC and St. Francis Medical Center which confirms the center would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The facility submitted a memorandum to Auditor which confirms there has not been an allegation of sexual abuse reported during the CAP period or any detainee-on-detainee abusers housed at HCDC during the CAP period. Upon review of all submitted documentation, or lack thereof, the Auditor now finds the facility in substantial compliance with subsections (a), (b), (c), (e), and (f) of the standard; however, continues to find the facility does not meet subsection (g).

§115. 86 - Sexual abuse incident reviews

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

Notes:

(a)(b)(c): HCDC policy 3C-21(a) mandates, "The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review shall ordinarily occur within 30 days of the conclusion of the investigation. The review team shall include administrative officials, with input from supervisors, investigators, and medical or mental health practitioners. The review team shall…Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility…" In addition, HCDC policy 3C-21(a) states, "Prepare a report of its findings, including but not limited to determinations made and any recommendations for improvement and

submit such report to the Director and PREA Coordinator. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so." The Auditor reviewed a PREA Review Committee memorandum stating in part that it was conducting a 30-day review as mandated in policy and upholding the final determination of the allegation; however, the memo only indicated that the review team agrees with the unsubstantiated finding and could not confirm that they took into consideration whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, a review of the submitted incident review could not confirm that the report and the review were submitted to the Agency PSA Coordinator. Interviews with the facility PSA Compliance Manager could not confirm the facility would conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation including where the allegation has been determined to be unfounded. In addition, interviews with the PSA Compliance Manager could not confirm the review team would consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, a report of its findings would be prepared including the determinations made and any recommendations for improvement, or the report and response is submitted to the Agency PSA Coordinator. The Auditor reviewed the HCDC annual report for 2022 and could not confirm the report included detainees or that the report included a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. In addition, a review of the annual report could not confirm that either was submitted to the facility administrator, the FOD, or the Agency PSA Coordinator.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b) and (c) of the standard. A review of HCDC policy C3-21(a) confirms it does not require the facility to conduct a sexual abuse incident review at the conclusion of unfounded allegations of sexual abuse. The Auditor reviewed a PREA Review Committee memorandum stating in part that it was conducting a 30-day review as mandated in policy and upholding the final determination of the allegation; however, the memo only indicated that the review team agrees with the unsubstantiated finding and could not confirm that they took into consideration whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, a review of the submitted incident review could not confirm that the report and the review were submitted to the Agency PSA Coordinator. The Auditor reviewed the HCDC annual report for 2022 and could not confirm the report included detainees or that the report included a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. In addition, a review of the annual report could not confirm that either was submitted to the facility administrator, the FOD, or the Agency PSA Coordinator. To become compliant, the facility must implement a practice that requires the review of all sexual abuse allegation investigations including those that are determined to be unfounded and to submit all reports and incident reviews to the Agency PSA Coordinator upon completion of the review. The facility must train all review team members on the standards requirement to consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility must implement a practice that includes detainee incidents of sexual abuse on the annual report and that the report includes a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. In addition, the facility must document that the annual report for 2022 has been submitted to the facility administrator, the FOD, and the Agency PSA Coordinator.

Corrective Action (a)(b)(c): The facility submitted updated policy HCDC-3C-21(a) which confirms updated policy HCDC-3C-21(a) requires the review of all sexual abuse allegation investigations including those determined to be unfounded and to submit all reports and incident reviews to the Agency PSA Coordinator upon completion of the review. A review of updated policy HCDC-3C-21(a) further confirms it includes the standards requirement to consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, a review of updated policy HCDC-3C-21(a) confirms it requires an annual report to include a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts and to submit said annual report to the FA, FOD, or his/her designee, and the Agency PSA Coordinator. The facility submitted an email to all sexual abuse incident team members and read receipts which confirm staff have received training on updated policy HCDC-3C-21(a). The facility submitted an email which confirms the annual report for 2022 was submitted to the facility administrator, the FOD, and the Agency PSA Coordinator. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

AUDITOR CERTIFICATION:

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

Jodi Upshaw January 17, 2024
Auditor's Signature & Date

(b) (6), (b) (7)(C) January 17, 2024
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) January 18, 2024
Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	2/14/2023	**To:**	2/16/2023
AUDITOR INFORMATION			
Name of auditor:	Jodi Upshaw	**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:	Saint Paul
Field Office Director:	Peter Berg
ERO PREA Field Coordinator:	Supervisory Detention and Deportation Officer (SDDO) (b) (6), (b) (7)(C)
Field Office HQ physical address:	1 Federal Drive, Suite 1600, Fort Snelling, MN 55111
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:	Hall County Department of Corrections		
Physical address:	110 Public Safety Drive, Grand Island, NE 68801		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	(308) 385-5211		
Facility type:	IGSA		
PREA Incorporation Date:	4/13/2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	308) 385-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Staff Sergeant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(308) 385-(b) (6), (b) (7)(C)

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	01/06/2023
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 Hall County Department of Corrections (HCDC) was conducted on March 14 – March 16, 2023, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Jodi Upshaw employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the U.S. ICE PREA auditing process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. HCDC is a county government facility governed by the Hall County Sheriff's Office (HCSO) and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The audit period is from April 13, 2020, through March 16, 2023. This is the first DHS PREA audit for HCDC.

The facility houses adult male and female detainees with low, medium, and high custody levels who are awaiting transportation to an ICE facility. The design capacity for the facility is 321 and is comprised of both inmates and ICE detainees that are comingled within the housing units. The average ICE detainee population for the prior 12 months was 9. The facility reported there were 103 ICE detainees booked into the facility in the last 12 months with an average length of stay of 42 days. On the first day of the audit the facility housed 12 detainees. The top three nationalities of the detainee population are Guatemalan, Mexican, and El Salvadorian. The facility is comprised of one building which includes male and female housing, administrative housing, a segregation unit, and medical area. There are two single occupancy cell housing units, two multiple occupancy cell housing units, three open bay/dorm housing units, and one unit that has both single and double occupancy cells. There are four single occupancy medical unit/infirmary cells. According to the Officer in Charge (OIC), detainees are brought into the booking area, classified, and would be assigned housing with Hall County inmates according to classification level. The booking area has a capacity to house 40 detainees to include multiple occupancy cells and a safety cell.

Approximately two weeks prior to the audit, the ERAU Team Lead (TL), (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), Agency policies, and other pertinent documents through the ICE SharePoint. The PAQ and supporting documentation were organized with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form and placed within folders for ease of auditing. The main policies that provide facility direction for HCDC are HCDC-3C-21 Sexual Abuse and Assault Prevention and Intervention Program (SAAPI) and HCDC-3C-21(a) Prison Rape Elimination Act (PREA). All documentation, policies, and the PAQ were reviewed by the Auditor. The Auditor also reviewed the facility's website, www.hallcountyne.gov/content.lasso?page=7497& and the Agency website www.ice.gov. A review of the facility website confirmed it does contain PREA information. A tentative daily schedule was provided by the Auditor for interviews with staff and detainees.

The entry briefing was held in the conference room on March 14, 2023. The ERAU TL opened the briefing. In attendance were:

(b) (6), (b) (7)(C) TL, Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU
(b) (6), (b) (7)(C) Director, HCDC
(b) (6), (b) (7)(C) Assistant Director, HCDC
(b) (6), (b) (7)(C) Lieutenant (Lt)/Officer in Charge (OIC), HCDC
(b) (6), (b) (7)(C) Staff Sergeant (S. Sgt)/Prevention of Sexual Assault (PSA) Compliance Manager, HCDC
(b) (6), (b) (7)(C) SDDO, ICE/ERO
Jodi Upshaw, Certified Auditor, Creative Corrections, LLC

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

The audit commenced on March 14, 2023, and included the sallyport, booking area, male and female housing units, recreation areas, library, medical and video courtroom. Detainees are housed in open bay/dorm style housing, single or multi-occupancy cells within a housing unit, or in a single segregation cell. Open bay/dorm style housing can house 16 to 36 detainees per unit. Single and multi-occupancy cell housing units have a maximum housing capacity of 12, 30, 36 or 60. Within each housing unit there is a common seating area, telephones, kiosks, and a bathroom with a toilet and shower. Above the telephone and on the walls are posters which included: the PREA audit notice, the DHS-prescribed sexual assault awareness notice, reporting numbers for the ICE Detention and Reporting and Information Line (DRIL), the contact information for the DHS Office of Inspector General (OIG), the HCDC zero-tolerance poster, the DHS-prescribed Sexual Abuse Awareness (SAA) Information pamphlet, and a poster that advised the detainee

the contact information for the foreign consulates office. All observed postings were in English and Spanish except for the HCDC zero-tolerance poster which was in English only. During the on-site tour, the Auditor noted sight lines, potential blind spots, and camera locations throughout the (b) (7)(E), (b) (7)(E), (b) (7)(E), (b) (7)(E), and the (b) (7)(E). There were no detainee intakes during the on-site audit. The detainees are fed through a satellite system in which meals are prepared and then delivered to the housing units by security staff.

HCDC has (b) (7)(E) located throughout all areas of the facility. The cameras run 24/7 and video footage is stored for 60 to 90 days on a digital video recorder before deletion. The Auditor observed placement of the video cameras and found them to be strategically placed in areas that benefit from additional surveillance to maximize detainee and staff safety. The Auditor viewed the camera site lines for direct viewing of toilet, shower and clothing changing areas and confirmed camera angles and use of gray boxes provided some privacy while a detainee was using the bathroom or showering; however, the Auditor observed (b) (7)(E) that would enable direct viewing in the booking area and within the housing units. In addition, the Auditor observed direct viewing into shower areas (b) (7)(E) of several housing units. In the booking area the Auditor observed a room used for changing clothes that has no window and provides privacy during change outs.

According to the PAQ, HCDC employs 87 staff to include security, non-security, and contractors. There are 74 security staff (47 male and 27 female) with duty hours from 0700 – 1900 and 1900 – 0700. The remaining staff consists of administration and maintenance staff, medical staff contracted through Advanced Correctional Healthcare (ACH), food service staff contracted through Summit Food Service, and volunteers. There are five ICE employees assigned to the Grand Island, Nebraska office who have reoccurring contact with detainees at HCDC.

The Auditor interviewed 17 staff members which consisted of the OIC, PSA Compliance Manager, Human Resources (HR) representative, a facility Investigator, Classification Supervisor, first line supervisor (1), Training Officer, Grievance Officer, booking Staff (1), custody first responder (2), a maintenance employee who was interviewed as a non-custody first responder, and random detention deputies (5). In addition, the Auditor further interviewed a Registered Nurse (RN) employed by Advanced Correctional Healthcare (ACH), an ICE Detention and Deportation Officer (DDO), and an ICE SDDO. During the on-site audit, the Auditor interviewed six detainees. Three detainees interviewed were limited English proficient (LEP) and required the use of a language line through Language Services Associates (LSA) provided by Creative Corrections. There were no volunteers present during the on-site audit for the Auditor to interview.

The facility PAQ reported there are seven facility investigators that have received specialized training on sexual abuse. There were two sexual abuse allegations reported during the audit period. A review of the PREA allegation spreadsheet indicated that there were two cases reported to ICE OPR and the JIC. One case involved a detainee-on-detainee and one case involved staff-on-detainee. Both cases were closed and determined to be unsubstantiated by a facility Investigator. There were no cases referred for prosecution.

On March 16, 2023, an exit briefing was held in the HCDC conference room. The ERAU TL opened the briefing. In attendance were:

(b) (6), (b) (7)(C) TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C) Director, HCDC
(b) (6), (b) (7)(C) Assistant Director, HCDC
(b) (6), (b) (7)(C) S. Sgt/PSA Compliance Manager, HCDC
(b) (6), (b) (7)(C) SDDO, ICE/ERO
Jodi Upshaw, Certified Auditor, Creative Corrections, LLC

The Auditor spoke briefly about non-compliance in the areas of cross gender viewing and training. The Auditor informed those in attendance that final compliance determinations could not be made until a review of documentation, site review notes, and interviews were compiled. The Auditor thanked those in attendance for their cooperation during the audit.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

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

Number of Standards Met: 14
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.34 Specialized training: Investigations
§115.54 Third-party reporting
§115.61 Staff and agency reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.66 Protection of detainees from contact with alleged abusers
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.78 Disciplinary sanctions for detainees
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 25
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.35 Specialized training: Medical and mental health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.71 Criminal and administrative investigations
§115.77 Corrective action for contractors and volunteers
§115.81 Medical and mental health screenings; 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

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)(d): HCDC policy 3C-21(a) outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment and states, "The Hall County Department of Corrections maintains a zero-tolerance policy for all forms of sexual abuse/harassment or assault. It is the policy of the Hall County Department of Corrections to provide a safe and secure environment for all inmates, employees, contractors, and volunteers…" HCDC policy 3C-21(a) further states, "The PREA Coordinator's responsibilities include developing, implementing, and overseeing the agency's plan to comply with PREA standards." The Auditor reviewed email correspondence between the PSA, SDDO, and the Assistant Field Officer Director (AFOD) of the Saint Paul Field Office that confirmed HCDC policy 3C-21(a) was approved by the Agency. During the on-site tour the Auditor observed the DHS-prescribed sexual assault awareness notice in the sally port, booking area, and on all the housing units in English and Spanish and the HCDC zero-tolerance posters in English. In an interview with the PSA Compliance Manager, it was indicated that he is the point of contact for both the facility and Agency PSA Coordinator. The PSA Compliance manager further indicated he has sufficient time and the authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. The Auditor reviewed the facility staffing plan and observed the PSA Compliance Manager reports to the Assistant Director and the Jail Lieutenant.

Recommendation (c): A review of HCDC policy 3C-21(a) identified the term inmates is used and does not include detainees; and therefore, the Auditor is making a general recommendation to update the HCDC policy 3C-21(a) to include detainees in their zero-tolerance policy.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): HCDC policy 3C-21(a) mandates, "Security staff provides the inmate supervision necessary to protect inmates from sexual abuse/harassment." HCDC policy 3C-21(a) further mandates, "The agency uses video monitoring systems and other cost-effective and appropriate technology to supplement its sexual abuse/harassment prevention, detection, and response efforts. The agency assesses, at least annually, the feasibility of and need for new or additional monitoring technology and develops a plan for securing such technology." HCDC policy 3C-07, Inspections, mandates, "The Shift Supervisor shall complete a Supervisor Unit Inspection sheet and document the completion of the daily tour in the Logbook and personnel log. Staff are prohibited from alerting other staff that these Supervisory rounds are occurring." A review of the facility PAQ indicated HCDC has a total of 74 security staff, consisting of 47 males and 27 females, who may have recurring contact with detainees. The remaining staff consists of support personnel in administration, maintenance, and food service. The facility staffing also includes eight medical contract staff employed by ACH. During the audit period, HCDC custody line staff were working two 12-hour shifts, 0700-1900 and 1900-0700. During the on-site tour the Auditor did observe appropriate staffing levels in the booking area and housing units where detainees are housed. There are a total of (b) (6), (b) (7)(C) strategically located throughout the facility. Video cameras operate 24/7 and have pan, zoom, and tilt, (PTZ) functionality. Cameras are continuously monitored by a staff member in the (b) (7)(E) Video feed can be observed in (b) (7)(E) and on the office computers of the (b) (7)(E), (b) (7)(E), and (b) (7)(E). During the on-site tour, the Auditor observed adequate cameras within the (b) (7)(E) and (b) (7)(E). In addition, the Auditor observed staff sight lines and camera views in the area which provided some privacy; however, the Auditor observed (b) (7)(E) that would enable direct viewing in the booking area within the housing units and direct viewing into shower areas (b) (7)(E) of several housing units. In an Interview with the PSA Compliance Manager, it was indicated that the facility does not use a staff-to-detainee ratio and required security checks are mandated for each housing unit that provide for sufficient supervision of detainees. The PSA Compliance Manager further confirmed he has access to camera footage that can be download in the (b) (7)(E) and saved for needed evidence. The Auditor reviewed three different days of supervisor unit inspection checklists and confirmed the supervisor was conducting the mandated unannounced sanitation and safety inspections required by HCDC Post Order 3A-01; however, the purpose of the rounds was not to identify and deter sexual abuse of detainees as required by subsection (d) of the standard. The Auditor reviewed 16 comprehensive supervision guidelines and confirmed 15 of the 16 comprehensive supervision guidelines had been reviewed in 2022. The facility did not provide documentation to confirm when determining adequate levels of detainee supervision and the need for video monitoring the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendation of sexual abuse incident review reports, or any other relevant factors, including but not limited to, the length of time detainees spend in Agency custody.

Does Not Meet (c)(d): The facility is not in compliance with subsections (c) and (d) of the standard. The facility did not provide documentation to confirm when determining adequate levels of detainee supervision and the need for video monitoring the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendation of sexual abuse incident review reports, or any other relevant factors, including but not limited to, the length of time detainees spend in Agency custody. In addition, the Auditor reviewed three different days of supervisor unit inspection checklists and confirmed the supervisor was conducting the mandated unannounced sanitation and safety inspections required HCDC Post Order 3A-01; however, the purpose of the rounds was not to identify and deter sexual abuse of detainees as required by subsection (d) of the standard. To become compliant, the facility must provide the Auditor with documentation to confirm when determining adequate staffing levels and the need for video monitoring, the facility took into consideration the physical layout of each holding facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors, including but not limited to the length of time detainees spend in Agency Custody. In addition, the facility must implement a practice that requires supervisors to make frequent unannounced security inspections on both day and night shifts to identify and deter sexual abuse of detainees as required by the standard. Once implemented the facility must submit documentation to confirm all supervisors were trained in conducting unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees. In addition, the facility must submit to the Auditor documentation of unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees for each month of the Corrective Action Plan (CAP) period.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b)(c)(d): According to the PAQ and interviews with the OIC, PSA Compliance Manager and five random detention deputies HCDC does not accept juvenile or family unit detainees; and therefore, the standard is not applicable.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(c)(d)(e)(f)(g)(i)(j): HCDC policy 3C-21(a) mandates, "Except in the case of emergency, the facility prohibits cross-gender strip and visual body cavity searches. Except in the case of emergency or other extraordinary or unforeseen circumstances, the facility restricts nonmedical staff from viewing inmates of the opposite gender who are nude or performing bodily functions and similarly restricts cross-gender pat-down searches. All cross-gender searches will be documented." HCDC policy 3C-21(a) further mandates, "The facility shall not allow for the searching or physical examination of a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or if necessary, the learning of that information as part of a broader medical examination conducted in private by a medical practitioner. Upon entering an opposite gender housing unit, staff shall announce their presence." A review of HCDC policy 3C-21(a) confirms it does not contain the verbiage "Cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances" or "cross-gender pat down searches of female detainees shall not be conducted unless in exigent circumstances." In addition, a review of HCDC policy 3C-21(a) confirms it does not require that all strip searches and body cavity searches be documented as required by subsection (f) of the standard. The Auditor reviewed a facility memo which states, "The Hall County Detention Center does not do cross-gender pat down searches;" however, in interviews with five random detention deputies and a first-line supervisor it was indicated although staff do not ordinarily conduct cross-gender searches (pat-down, strip or body cavity) should one be necessary, due to an emergency situation, the search would be documented electronically in the facility Spillman system. In addition, in an interview with five detention deputies it was indicated detainee strip searches would additionally be documented on the U.S. Department of Justice Immigration and Naturalization Service Record of Search Form. In interviews with five random detention deputies and a first-line supervisor it was further indicated that a search or physical examination of a detainee for the sole purpose of identifying a detainee's genital status is never allowed; however, interviews could not confirm that all strip searches and body cavity searches would be documented. The Auditor reviewed a video of staff conducting a pat-down search and confirmed staff conducting the pat down search was the same gender as the detainee being searched. During the on-site tour, although the Auditor did not observe cross-gender issues when it came to detainees changing clothing, the Auditor observed (b) (7)(E) that would enable direct viewing in the booking area and within some of the housing units and direct viewing into shower areas (b) (7)(E) of several housing units. In addition, the Auditor observed staff of the opposite gender announcing their presence as they entered male or female housing units. In interviews with five random detention deputies and a first-line supervisor it was indicated all have received training in proper procedures for conducting pat-down searches including in a professional and respectful manner and in the least intrusive manner possible. The Auditor reviewed the HCDC training curriculum for pat-down searches and confirmed it included cross-gender pat-down searches and searches of transgender and intersex detainees. In addition, the training curriculum included the requirement that all pat-down searches will be conducted in a professional and respectful manner and in the least intrusive manner possible. During an interview with the training officer the Auditor confirmed that training is conducted electronically through a system entitled RELIAS. The Auditor reviewed the training records of three HCDC staff and confirmed all three had received training as required by the standard. The facility does not house juvenile detainees.

Does Not Meet (f)(g): The facility is not in compliance with subsections (f) and (g) of the standard. A review of HCDC policy 3C-21(a) confirms it does not require that all strip searches and body cavity searches will be documented as required by subsection (f) of

the standard. In addition, during the on-site tour the Auditor observed (b) (7)(E) that would enable direct viewing in the booking area and within the housing units. In addition, the Auditor observed direct viewing into shower areas (b) (7)(E) of several housing units. To become compliant, the facility must develop a practice that requires all strip and body cavity searches be documented and not just cross-gender. Once implemented the facility must provide documentation that all detention deputies and first line supervisors have been trained on the requirement to document all strip and body cavity searches. In addition, the facility must implement a practice that provides privacy for all detainees to shower and perform bodily functions without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine jail checks. Once implemented the facility must provide the Auditor with documentation that confirms the cross-gender viewing issues are no longer a concern.

Recommendation (b)(c): The Auditor recommends that HCDC policy 3C-21(a) be updated to include the verbiage "Cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances" or "cross-gender pat down searches of female detainees shall not be conducted unless in exigent circumstances."

Recommendation (f): The U.S. Department of Justice Immigration and Naturalization Service Record of Search Form is utilized for detainees that are strip searched. The Auditor recommends that this form be updated to reflect the current form of the U.S. Department of Homeland Security, Immigrations and Customs Enforcement.

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

§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): HCDC policy 61-07, Disability Identification Assessment and Accommodation, mandates, "Throughout the facility's programs and activities, including at all stages of the reasonable accommodation process, the facility must take appropriate steps to allow for effective communication with detainees with disabilities to afford them an equal opportunity to participate in, and enjoy the benefits of, the facility's programs and activities. Steps to ensure effective communication may include the provision and use of auxiliary aids or services for detainees with vision, hearing, sensory, speech, and manual impairments, as needed. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual detainee, the nature, length, and complexity of the communication involved, and the context in which the communication is taking place. In determining what types of auxiliary aids or services are necessary, the facility shall give primary consideration to the request of the detainee with a disability. Use of other detainees to interpret or facilitate communication with a detainee with a disability may only occur in emergencies." A review of the facility handbook confirms it contains the facility's zero-tolerance policy and information on how to report an allegation of sexual abuse; however, the handbook was only available in English and Spanish on-site. In an interview with booking staff, it was indicated the ICE National Detainee Handbook would be distributed to the detainee in English and Spanish only if he/she didn't have one. During the on-site tour, the Auditor observed posted above the telephone and on the walls the DHS-prescribed sexual assault awareness notice, reporting numbers for the DRIL, the contact information for the DHS OIG, HCDC zero-tolerance poster, the DHS-prescribed SAA Information pamphlet, and a poster that advised the detainee the contact information for the foreign consulate's office. All observed postings were in English and Spanish except for the HCDC zero-tolerance poster which was posted in English only. In addition, the Auditor observed handheld devices utilized by floor staff. These devices interface with the Guardian System utilized by HCDC and provides staff with a means to utilize Google Translate to communicate with detainees as needed. The Auditor also observed kiosk machines on the housing units run by CIDNET Communications and confirmed information provided on this system was in English and Spanish only. During the on-site tour the PSA Compliance Manager attempted to locate the ICE National Detainee Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-prescribed SAA Information pamphlet available in the remaining 13 most prevalent languages encounter by ICE: Portuguese, Arabic, Hindi, Punjabi, Chinese, Haitian Creole, and French; however, not all could be located. In an interview with the OIC it was indicated that a Talk to Text (TTY) machine is available for facility use to provide detainees who are deaf or hard of hearing with the required PREA information; however, during interviews with booking staff they indicated the TTY machine was not used and they were unable to articulate how the TTY machine worked. In addition, in interviews with booking staff it was indicated they would use multiple ways to provide PREA information to detainees who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities, and those who have limited reading skills including, but not limited to, speaking slowly for those detainees who have intellectual or psychiatric disabilities, speaking, louder for those detainees who have a hearing disability, and reading material or providing written communication for those detainees who may have a vision disability. However, in interviews with booking staff it was confirmed they could not articulate how to use the language line or the alternative verbal and written methods they noted they would use. During interviews with six detainees, it was indicated that three of the four remembered receiving an ICE National Detainee Handbook; however, only two remembered receiving a facility handbook. Three detainees interviewed reported they could not speak with staff during booking/processing and advised staff they need assistance in translation and interpretation; however, the only time the language line had been utilized for communication was during the on-site interview with the Auditor.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. During the on-site tour the Auditor confirmed the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet was available on-site to the detainee population in English and Spanish: however, the PSA Compliance Manager attempted to locate the ICE National Detainee

Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-prescribed SAA Information pamphlet remaining in the 13 additional most prevalent languages encounter by ICE: Portuguese, Arabic, Hindi, Punjabi, Chinese, Haitian Creole, and French; however, not all could be located. Interviews with booking staff and detainees confirmed the facility provides PREA information to the detainee in English and Spanish only. In addition, although during interviews with booking staff it was indicated PREA information would be given in alternative ways they could not articulate how to use the language line, TTY machine, or the alternative verbal and written methods to give detainees the information. In interviews with three LEP detainees it was indicated that the only time the facility language line was used was during the Auditors on-site interview. To become compliant, the facility must take appropriate steps to ensure detainees with disabilities, including those who are LEP, have equal access to all aspects of the Agency and facility's efforts to prevent, detect, and respond to sexual abuse. In addition, the facility must implement a practice that includes having the DHS-Prescribed SAA Information pamphlet, in the 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) and the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) available to the detainee on-site. Once implemented the facility must submit documentation that all booking staff have been trained on the new practice. The facility must submit to the Auditor 10 detainee files that include detainees who are received at HCDC during the CAP period to confirm the new practice has been implemented. If applicable, the submitted files should include a sampling of detainees who are LEP, deaf or hard of hearing, blind or have limited sight, or may have intellectual, psychiatric, or a speech disability.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." The ICE Personnel Security and Suitability Program policy outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." HCDC policy 3C-21(a), mandates, "The agency does not hire or promote anyone who has engaged in sexual abuse/harassment in an institutional setting or who has engaged in sexual activity in the community facilitated by force, the threat of force, or coercion. Consistent with Federal, State, and local law, the agency makes its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse/harassment; must run criminal background investigation for all contractors, volunteers, applicants and employees being considered for employment or promotion; and must examine and carefully weigh any history of criminal activity at work or in the community, including convictions for domestic violence, stalking, and sex-offenses. Background investigations will be performed on all contracted staff, volunteers, and employees every 3 years. The agency also asks all applicants and employees directly about previous misconduct during interviews and reviews." A review of HCDC policy 3C-21(a) confirms it does not include the requirements to not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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 prior to promotion staff shall be asked about previous misconduct during an interview or by written application. The Auditor reviewed the employee application and could not confirm material omissions regarding sexual misconduct or the providing of materially false information would be grounds for termination or withdrawal of an offer of employment. In an interview with an HR representative it was indicated new hires must complete a background investigation successfully prior to hire and the PREA related questions are included in both the employment documents and as part of the promotional process; however, the HR representative could not confirm the facility would not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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. The HR representative further indicated that unless prohibited by law the facility would share any relevant information on substantiated allegations of sexual abuse involving a former employee applying to a different institutional employer. The Auditor reviewed 12 staff personnel files and confirmed initial, and five year required background checks completed in all 12 files; however, only 1 staff personnel file included a signature on a yearly performance review that asked, "Have you engaged in sexual harassment or sexual abuse with an inmate or staff member?" A further review of the yearly performance review confirmed it does not require the employee to disclose all required elements of subsection (a) of the standard. In an interview with an ICE SDDO it was indicated there have not been any new hires or promotions for ICE staff during the audit period. The Auditor submitted a Background Investigation for Employees and Contractors form to the OPR PSO Unit which included three ICE employees assigned to the facility to verify the completion of the background process. OPR PSO confirmed background investigations were completed for all staff submitted.

Does Not Meet (a)(b)(e): The facility is not in compliance with subsections (a), (b) and (e) of the standard. A review of HCDC policy 3C-21(a) confirms it does not include the requirements to not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse or who has been civilly or administratively adjudicated to have engaged in such activity. In an interview with an HR representative it was indicated new hires must complete a background investigation successfully prior to hire and the PREA related questions are included both in the employment documents and as part of the promotional process; however, the HR representative could not confirm the facility would not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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 prior to promotion staff shall be asked about previous misconduct during an interview or by written application. The Auditor reviewed the employee application and could not confirm material omissions regarding sexual misconduct or the providing of materially false information would be grounds for termination or withdrawal of an offer of employment. The Auditor reviewed 12 staff personnel files and confirmed only 1 staff personnel file included a signature on a yearly performance review that asked, "Have you engaged in sexual harassment or sexual abuse with an inmate or staff member?" A further review of the yearly performance review confirmed it does not require the employee to disclose all required elements of subsection (a) of the standard. To become compliant, the facility must implement a practice to not hire, promote, or use the services of any contractor or volunteer who may have contact with detainees who has been civilly or administratively adjudicated to have engaged 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 and material omissions regarding sexual misconduct or the providing of materially false information would be grounds for termination or withdrawal of an offer of employment and provide the Auditor with documentation that the practice has been implemented. In addition, the facility must update the yearly performance review to include all the required elements of subsection (a) of the standard. Once implemented the facility must provide documentation that all HR staff have been trained on the new practice. In addition, the facility must provide the Auditor with 15 personnel files that confirm that both practices have been implemented and that staff have a continuing affirmative duty to report any misconduct involving sexual abuse as required by subsection (a).

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): A review of the PAQ and interviews conducted with the OIC and PSA Compliance Manager confirmed the facility has not acquired a new facility or made a substantial expansion to the existing facility or installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology during the audit period. Therefore, subsections (a) and (b) of the standard are not applicable.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): The Agency's policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." HCDC policy 3C-21(a) mandates, "The agency follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol must be adapted from or otherwise based on the 2004 U.S. Department of Justice's Office on Violence Against Women publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," subsequent updated editions, or similarly comprehensive and authoritative protocols developed after 2004. As part of the Hall County Department of Corrections evidence collection protocol, all victims of inmate-on-inmate sexual abuse or staff-on-inmate sexual abuse are provided access to forensic medical exams performed by qualified forensic medical examiners. Forensic medical exams are provided free of charge to the victim. The facility makes available a victim advocate to accompany the victim through the forensic medical exam process." A review of HCDC policy 3C-21(a) and an interview with the SDDO confirmed the policy was developed in coordination with DHS. The Auditor reviewed a signed Memorandum of Understanding (MOU) dated January 13, 2020, between HCDC and the Crisis Center of Grand Island with no listed end date and confirmed services provided by the Crisis Center of Grand Island will include emotional support, crisis intervention, information and referrals, and a victim advocate to ensure that a victim's interests are represented. In addition, the Auditor reviewed a MOU signed on January 23, 2020, between HCDC and the Director of Emergency Services for Catholic Health Initiative (CHI) St. Francis with no end date that confirmed CHI St. Francis, will provide the expertise of two Sexual Assault Nurse Examiners (SANE) to provide services to HCDC as needed. The Auditor was provided documentation signed on March 13, 2023, by the Sheriff of Hall County that provides for criminal investigations for inmate-on-inmate situations. Additionally, should a conflict arise, such as staff-on-inmate situation, the case would be turned over to the Hall County Attorney's office who will request that an outside agency investigate. This MOU also provides for a detainee housed under contract with the DHS with contact to that agency and involvement in the case. Interviews with the OIC, PSA Compliance Manager, and facility Investigator confirmed that should an allegation of sexual abuse or assault occur the incident would be reported immediately to ICE/ERO. The OIC further indicated Hall County Sheriff's Department would be notified to refer criminal behavior for

prosecution or refer the incident back to HCDC for an administrative investigation. In an interview with the facility RN, it was confirmed that the facility would utilize the services of CHI St. Francis during an incident of sexual abuse for forensic examinations and this treatment would be provided free of charge for the detainee. The facility submitted a memorandum from the Sheriff of Hall County confirming that the Hall County Sheriff's Department will investigate all criminal activity that occurs at HCDC; however, the facility did not submit documentation that they requested the Hall County Sheriff's Department follow the requirements of (a) through (d) of the standard. A review of two sexual abuse allegation investigation files indicated that no detainee was sent to the hospital for a forensic medical exam during the audit period. The facility does not house juvenile detainees.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. The facility submitted a memorandum from the Sheriff of Hall County confirming that the Hall County Sheriff's Department will investigate all criminal activity that occurs at HCDC; however, the facility did not submit documentation that they requested the Hall County Sheriff's Department follow the requirements of (a) through (d) of the standard. To become compliant, the facility must provide documentation that they have requested that the Hall County Sheriff's Department follow the requirements of subsections (a) through (d) of the standard.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): The Agency provided policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly, if necessary, b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE Significant Event Notification (SEN) Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." HCDC policy 3C-21 mandates, "The facility shall employ procedures for an internal administrative investigation that shall be conducted in all cases only after consultation with the assigned criminal investigative entity or after the criminal investigation has concluded. Such procedures shall establish the coordination and sequencing of the two types of investigations, to ensure that the criminal investigation is not compromised by an internal administrative investigation. All incidents and allegations of sexual abuse or assault shall be reported immediately." HCDC policy 3C-21 further states, When an inmate(s) is alleged to be the perpetrator, it is the Director's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and report to Field Office Director (when ICE detainee (s) involved" and "when an employee, contractor, or volunteer is alleged to the perpetrator of inmate sexual abuse or assault it is the Director's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and report to Field Office Director (when ICE detainee (s) involved." In addition, HCDC policy C3-21 states, "The Department retains all reports for as long as the alleged abuser is incarcerated or is employed by the Department plus five years." A review of HCDC policy 3C-21 confirms the policy does include the description of responsibilities of the agency, facility, and any other investigating entities as required by subsection (a) of the standard. In addition, a review of HCDC policy C3-21 confirms it does not contain the verbiage when a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (e) or the verbiage when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (f) of the standard. In interviews with the OIC, PSA Compliance Manager, and facility Investigator it was indicated all allegations of sexual abuse would be referred for investigation and that such records will be maintained in hard copy and electronic format for at least 10 years. Interviews further indicated when a detainee, prisoner, inmate, or resident of the facility where the detainee victim is a housed is alleged to be the perpetrator of detainee sexual abuse or staff member, contractor or volunteer is the perpetrator of detainee sexual abuse, the facility will notify the appropriate ICE FOD and appropriate investigative authority. In an interview with the SDDO it was indicated notification to the JIC would be made immediately upon notification from HCDC. The Auditor reviewed the PREA allegation spread sheet provided with the PAQ and confirmed both closed cases were referred to ICE OPR and the JIC. During a review of the Agency and the facility website, it was confirmed that the Agency website does include the Agency protocol and is located (https://www.ice.gove/detain/prea); however, the facility protocol for investigations HCDC policy C3-21 is not made available to the public on the HCDC website www.hallcountyne.gov/content.lasso?page=7497&.

Does Not Meet (a)(b)(c)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (c), (d), (e) and (f) of the standard. A review of HCDC policy 3C-21 confirms the policy does not include the description of responsibilities of the agency, facility, and any other investigating entities as required by subsection (a) of the standard. In addition, a review of HCDC policy C3-21 confirms it does not contain the verbiage when a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident s promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (e) or the verbiage when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (f) of the standard. The Auditor reviewed the HCDC website www.hallcountyne.gov/content.lasso?page=7497& and confirmed it does not include the facility investigative protocol HCDC policy C3-21. To become compliant, the facility must update HCDC policy C3-21 to include a description of the

responsibilities of the agency, facility, and any other investigating entities and the verbiage "when a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG" and "when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG." Once implemented the facility must submit documentation that all applicable staff have been trained on the updated protocol. In addition, the facility must include the facility protocol, HCDC policy C3-21, on the facility website www.hallcountyne.gov/content.lasso?–age=7497&.

§115.31 - Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): HCDC policy 3C-21 mandates, "The agency trains all employees to be able to fulfill their responsibilities under agency sexual abuse/harassment prevention, detection, and response policies and procedures; the PREA standards; and relevant Federal, State, and local law. The agency trains all employees to communicate effectively and professionally with all inmates. Additionally, the agency 'rains all employees on an inmate's right to be free from sexual abuse/harassment, the right of inmates and employees to be free from retaliation for reporting sexual abuse/harassment, the dynamics of sexual abuse/harassment in confinement, and the common reactions of sexual abuse/harassment victims. Current employees are educated as soon as possible following the agency's adoption of the PREA standards, and the agency provides at a minimum every 2-year refresher information to all employees to ensure they know the agency's most current sexual abuse/harassment policies and procedures. The agency maintains written documentation showing employee signatures verifying that employees understand the training they have received." The Auditor reviewed the facility PREA training curriculum which includes: the facility's zero-tolerance policy, definitions and examples of prohibited and illegal sexual behavior, rights of detainees and staff to be free from sexual abuse and retaliation for reporting sexual abuse, recognition of situations where sexual abuse may occur, recognition of physical, behavioral and emotional signs of sexual abuse, how to avoid inappropriate relationships with detainees, and facility procedures for reporting knowledge or suspicion of sexual abuse. However, a review of the facility PREA training curriculum confirmed it does not include the Agency's zero-tolerance policy, the requirement to limit reporting of sexual abuse to personnel on a need-to-know basis in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes, or how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees. The Auditor reviewed the RELIAS training system and confirmed staff receive documented refresher training every two years as required by subsection (b) of the standard. In addition, the Auditor reviewed ICE staff training records documented on PALMS and confirmed ICE staff received training as required by the standard.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of the facility PREA training curriculum confirmed it does not include the Agency's zero-tolerance policy, the requirement to limit reporting of sexual abuse to personnel on a need-to-know basis in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes, or how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees. To become compliant, the facility must submit documentation that the facility PREA training curriculum includes all elements of subsection (a) of the standard. In addition, the facility must provide documentation that all staff who have contact with detainees have received training on the–updated curriculum.

§115.32 - Other training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): HCDC policy 3A-21(a) mandates, "The agency ensures that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency's sexual abuse/harassment prevention, detection, and response policies and procedures; the PREA standards; and relevant Federal, State, and local law. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with inmates, but all volunteers and contractors who have contact with inmate's must be notified of the agency's zero-tolerance policy regarding sexual abuse/harassment. Volunteers must also be trained in how to report sexual abuse/harassment. The agency maintains written documentation showing volunteer and contractor signatures verifying that they understand the training they have received." The Auditor reviewed the HCDC Volunteer Orientation and Training Manual. In addition, the Auditor reviewed PREA training acknowledgement forms submitted by the facility and confirmed volunteers are notified of the agency and facility zero-tolerance policies regarding sexual abuse and are informed on how to report such incidents; however, in an interview with the PSA Compliance Manager it was confirmed other contractors, as outlined in subsection (d) of the standard, are not provided training on their responsibilities under the Agency and the facility sexual abuse prevention, detection, intervention and response policies and procedures.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. In an interview with the PSA Compliance Manager it was confirmed the facility does not provide other contractors, as outlined in subsection (d) of the standard, the Agency and facility zero-tolerance policies regarding sexual abuse or does the facility inform other contractors how to report incidents of sexual abuse. To become compliant the facility must submit documentation to the Auditor that all other contractors, as outlined in subsection (d) of the standard, have received training on the Agency's and facility's zero-tolerance policies regarding sexual abuse and how to report an incident of sexual abuse.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

a)(b)(c)(d)(e)(f): HCDC policy 3C-21(a) mandates, "During the intake process staff informs inmates of the agency's zero-tolerance policy regarding sexual abuse/harassment and how to report incidents or suspicions of sexual abuse/harassment. Within a reasonably brief period of time following the intake process, the agency provides comprehensive education to inmates regarding their right to be free from sexual abuse/harassment and to be free from retaliation for reporting abuse/harassment, the dynamics of sexual abuse/harassment in confinement, the common reactions of sexual abuse/harassment victims, and agency sexual abuse/harassment response policies and procedures." HCDC policy 3C-21(a) further states, "The agency provides inmate education in formats accessible to all inmates, including those who are LEP, deaf, visually impaired, or otherwise disabled as well as inmates who have limited reading skills. The agency maintains written documentation of inmate participation in these education sessions." During the on-site tour, the Auditor observed posted above the telephone and on the walls the DHS-prescribed sexual assault awareness notice, reporting numbers for the DRIL, the contact information for the DHS OIG, the telephone number of the Crisis Center, Inc., the DHS-prescribed SAA Information pamphlet, and a poster that advised the detainee the contact information for the foreign consulate's office. All observed postings were in English and Spanish except for the HCDC zero-tolerance poster, which included the name of the PSA Compliance Manager, which was posted in English only. In addition, the Auditor accessed the housing unit kiosks and confirmed the kiosks contained the HCDC zero-tolerance poster, in English only, ICE PREA information in English and Spanish, contact information for the foreign consulate offices, ICE Hope poster, the DHS-prescribed sexual abuse and assault awareness notice, the ICE National Detainee Handbook in English and Spanish, the facility handbook in English and Spanish and the PREA orientation video in English and Spanish. During the on-site tour the PSA Compliance Manager attempted to locate the ICE National Detainee Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali; and the DHS-prescribed SAA Information pamphlet available in the remaining 13 most prevalent languages encountered by ICE: Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese ; however, not all were located. The Auditor reviewed the HCDC orientation PowerPoint presentation and confirmed it contained facility specific information on what a detainee should do it they are sexually assaulted; however, the information is available in English and Spanish only. In an interview with the OIC it was indicated that a Talk to Text (TTY) machine is available for facility use to provide detainees who are deaf or hard of hearing with the required PREA information; however, during interviews with booking staff they indicated the TTY machine was not used and they were unable to articulate how the TTY machine worked. In addition, in interviews with booking staff it was indicated they would use multiple ways to provide PREA information to detainees who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities, and those who have limited reading skills including, but not limited to, speaking slowly for those detainees who have intellectual or psychiatric disabilities, speaking, louder for those detainees who have a hearing disability, and reading material or providing written communication for those detainees who may have a vision disability. However, in interviews with booking staff it was confirmed they could not articulate how to use the language line or the alternative verbal and written methods they noted they would use. In addition, in interviews with booking staff, it was indicated the facility handbook can be printed in additional languages as needed; however, booking staff could not articulate how this would be accomplished or in what languages the facility handbook could be printed. During interviews with six detainees, it was indicated that three of the four remembered receiving an ICE National Detainee Handbook; however, only two remembered receiving a facility handbook. Three detainees interviewed reported they could not speak with staff during booking/processing and that they needed assistance in translation and interpretation; however, the only time the language line had been utilized for communication was during the on-site interview with the Auditor. The Auditor reviewed a Receipt for Property and Personal Use Items Issued document and confirmed the detainee signs that they have viewed an orientation video and they understand it and that the document includes a line for "PREA received and understands." The Auditor reviewed six detainee files and confirmed all detainees signed for PREA education received at intake; however, the Auditor could not confirm the information was provided in a manner that all detainees could understand. The Auditor reviewed the ICE National Detainee Handbook and confirmed it included information on how to report an incident of sexual abuse; however, the Auditor could not confirm that the ICE National Detainee Handbook or DHS-prescribed SAA pamphlet Information pamphlet was available on-site, in other than English and Spanish, or could booking staff articulate how the ICE National Detainee Handbook or DHS-prescribed SAA pamphlet Information pamphlet would be provided in another language if need be. In an interview with booking staff, it could not be confirmed if the video included a closed-caption function for the deaf or hard of hearing.

Does Not Meet (a)(b)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (d), (e), and (f) of the standard. A review of HDCD policy confirms within a reasonably brief period of time following the intake process the facility will provide the detainee with orientation. In addition, a review of a detainee signed "Receipt for Property and Personal Use Items Issued" could not confirm what PREA orientation the detainee received simply stating "PREA received and understands." During the on-site tour, the Auditor observed posted above the telephone and on the walls the telephone number of the Crisis Center, Inc., in English and Spanish, and the HCDC zero-tolerance poster, which included the name of the PSA Compliance Manager, in English only. The Auditor reviewed the ICE National Detainee Handbook and confirmed it included information on how to report an incident of sexual abuse; however, the Auditor could not confirm that the ICE National Detainee Handbook or DHS-prescribed SAA Information pamphlet was available on-site, in other than English and Spanish, or could booking staff articulate how the ICE National Detainee Handbook or DHS-prescribed SAA Information pamphlet would be provided in another language if need be. During the on-site audit the PSA Compliance Manager attempted to locate the ICE National Detainee Handbook in the remaining 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-prescribed SAA Information pamphlet available in the remaining 13 most prevalent languages encountered by ICE: Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however,

they could not be located. The Auditor reviewed HCDC orientation PowerPoint presentation and confirmed it contained facility specific information on what a detainee should do if they are sexually assaulted; however, the information was only available in English and Spanish. Interviews with booking staff and detainees confirmed the facility provides PREA information to the detainee in English and Spanish only. In addition, although during interviews with booking staff it was indicated PREA information would be given in alternative ways they could not articulate how to use the language line, TTY machine, or the alternative verbal and written methods to give detainees the information. In interviews with booking staff, it was indicated the facility handbook could be printed in additional languages as needed; however, booking staff could not articulate in what additional languages the facility handbook could be printed or by what method. To become compliant, the facility must develop and implement a PREA Orientation program during the intake process that includes each element required in subsection (a) of the standard in a manner they can understand. The facility must make available and distribute during the orientation process the DHS-prescribed SAA Information pamphlet available in the most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian). The facility must post the DHS-prescribed sexual abuse and assault awareness notice, or the HCDC zero-tolerance poster, with the name of the PSA Compliance Manager; and information regarding Crisis Center, Inc. on all housing unit bulletin boards in a manner that all detainees can understand, including detainees who do not speak English, and submit documentation the signage has been posted. The facility must provide the information available in the orientation video to detainees in a manner all detainees can understand. In addition, the facility must provide the Auditor with 10 detainee files, which include detainees who do not speak English or Spanish, and if applicable, detainees who are blind or have limited sight, who are deaf or hard of hearing, or otherwise disabled, to confirm they are participating in an orientation program during the intake process, to include, but is not limited to, the orientation video, the facility handbook, and the DHS-prescribed SAA Information pamphlet in a manner they can understand.

§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 Agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. HCDC policy 3C-21(a) mandates, "In addition to the general training provided to all employees, the agency ensures that agency investigators conducting sexual abuse/harassment investigations have received comprehensive and up-to-date training in conducting such investigations in confinement settings. Specialized training must include techniques for interviewing sexual abuse/harassment victims, proper use of Miranda and Garrity type warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The agency maintains written documentation that investigators have completed the required specialized training in conducting sexual abuse/harassment investigations." The Auditor was provided with certificates of completion from the National Institute of Corrections for the course: PREA: Investigating Sexual Abuse in a Confinement Setting for all facility Investigators. The Auditor reviewed the training curriculum and confirmed it included all elements required by the standard.

Recommendation (a): The Auditor recommends that the facility update HCDC policy 3C-21(a) to include effective cross-agency coordination.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

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

(b)(c): HCDC policy 3C-21(a) mandates, "The agency ensures that all full- and part-time medical and mental health care practitioners working in its facilities have been trained in how to detect and assess signs of sexual abuse/harassment and that all medical practitioners are trained in how to preserve physical evidence of sexual abuse. All medical and mental health care practitioners must be trained in how to respond effectively and professionally to victims of sexual abuse/harassment and how and to whom to report allegations or suspicions of sexual abuse/harassment. The agency maintains documentation that medical and mental health practitioners have received this specialized training." A review of HCDC policy 3C-21(a) and an interview with the SDDO confirmed the policy was reviewed and approved by the agency. In an interview with a facility RN it was indicated mandatory specialized training has been completed through Advanced Correctional Healthcare (ACH); however, the Auditor was not provided with a complete training curriculum or staff training records; and therefore, could not confirm all elements of subsection (b) are included in the training or that all medical and mental health staff have received the training as required by the standard.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. In an interview with a RN, it was indicated mandatory specialized training has been completed through ACH; however, the Auditor was not provided a complete training

curriculum or staff training records; and therefore, could not confirm all elements of subsection (b) are included in the training or that all medical and mental health staff have received the training as required by the standard. To become compliant, the facility must provide a copy of the training curriculum to confirm it is compliant with subsection (b) of the standard. If it is not, the facility must develop and implement a training curriculum that meets the standards requirements. In addition, the facility must provide the Auditor with documentation that all medical and mental health staff have received the training as required by subsection (b) of the standard.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f)(g): HCDC policy 3C-21(a) mandates, "All inmates are screened during intake, during the initial classification process, and at all subsequent classification reviews to assess their risk of being sexually abused by other inmates or sexually abusive toward other inmates. Employees must conduct this screening using a written screening instrument tailored to the gender of the population being screened." HCDC 3C-21(a) further states, "At a minimum, employees use the following criteria to screen male inmates for risk of victimization: mental or physical disability, young age, slight build, first incarceration in prison or jail, nonviolent history, prior convictions for sex offenses against an adult or child, sexual orientation of gay or bisexual, gender nonconformance (e.g., transgender or intersex identity), prior sexual victimization, and the inmate's own perception of vulnerability. At a minimum, employees use the following criteria to screen male inmates for risk of being sexually abusive: prior acts of sexual abuse/harassment and prior convictions for violent offenses. At a minimum, employees use the following criteria to screen female inmates for risk of sexual victimization: prior sexual victimization and the inmate's own perception of vulnerability. At a minimum, employees use the following criteria to screen female inmates for risk of being sexually abusive: prior acts of sexual abuse/harassment. Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to screening questions. The department shall implement appropriate controls on the dissemination within the facility of responses to questions asked to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates." A review of HCDC policy 3C-21(a) confirms it does not include whether the male detainee has a developmental disability, limits the screening to male detainees who are young or slight of build, or a history of prior institutional violence or sexual abuse, as known to the facility. In addition, a review of HCDC policy 3C-21(a) confirms when screening female detainees the facility does not take into consideration mental, physical, or developmental disability, the age of the detainee, the physical build and appearance of the detainee, whether the detainee has previously been incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, the detainee's own concerns about her physical safety, or prior convictions for violent offenses and a history of institutional violence or sexual abuse as known to the facility. A review of HCDC policy 3C-21(a) further confirms the policy does not require a reassessment for risk of sexual victimization upon receipt of additional information or following an incident of abuse or victimization or that the detainee be kept separate from the general population until he/she is classified and may be housed accordingly. During the on-site tour, and in interviews with booking staff, it was indicated during intake, detainees are assessed for the likelihood of being a sexual aggressor or sexual abuse victim. All detainees are held within the booking area until booking is completed. Interviews with booking staff further indicated the detainee is asked the questions from the initial PREA Assessment form; however, the Auditor reviewed a completed assessment form and confirmed it did not consider whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In an interview with the classification officer, it was indicated that a reassessment would be completed utilizing the same form as the initial assessment. In an interview with the classification officer and PSA Compliance Manager it was indicated the assessment is completed on the jail system which is called Spillman. The Spillman system grants system access based on defined job roles. The Classification officer and PSA Compliance Manager further indicated a detainee would not be disciplined for refusing to answer any questions on the assessment and that a reassessment would be completed after an incident of sexual abuse or when additional information was received that would warrant an assessment being completed. The Auditor reviewed six detainee files and confirmed initial classification and housing assignments were completed within 12 hours of admission in all files. In addition, a review of the six detainee files confirmed two reassessments, although due, were not completed between 60 and 90 days as required by subsection (e) of the standard. A review of two investigation files indicated one detainee was provided the required reassessment and the other was released prior to the required reassessment being conducted.

Does Not Meet (c)(e): The facility is not in compliance with subsections (c) and (e) of this standard. The Auditor reviewed a provided completed assessment form and confirmed it did not include the facility considered whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In addition, the Auditor reviewed six detainee files and confirmed two of the files, although due, did not include a reassessment for risk of sexual abuse or sexual aggression between 60 and 90 days as required by subsection (e) or the standard. The Auditor reviewed two sexual abuse allegation investigation files and confirmed only one file included the reassessment after an incident of sexual abuse as required by the standard. To become compliant, the facility must implement a practice that requires the facility to consider whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. The facility must train all applicable staff on the new practice and document such training. The facility must provide the Auditor with 10 detainee files to confirm that the facility Initial PREA Assessment form/process has been updated. In addition, the facility must implement a practice that ensures all detainees are reassessed for risk of abusiveness or victimization between 60-90 days of the initial assessment and after an incident of sexual abuse. Once implemented the facility must provide documentation that all classification staff are trained on the new practice. If applicable, the facility must provide the Auditor with 10 detainee files that include reassessments of detainee's risk of victimization and abusiveness, between 60-and-90 days of the initial assessment. The facility must submit to the Auditor all sexual abuse investigation files that occurred during the CAP period and the corresponding reassessment.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): HCDC policy 3C-21(a) mandates, "Employees use information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. The facility makes individualized determinations about how to ensure the safety of each inmate. Lesbian, gay, bisexual, transgender, or other gender-nonconforming inmates are not placed in particular facilities, units, or wings solely on the basis of their sexual orientation, genital status, or gender identity. Inmates at high risk for sexual victimization may be placed in segregated housing only as a last resort and then only until an alternative means of separation from likely abusers can be arranged. To the extent possible, risk of sexual victimization should not limit access to programs, education, and work opportunities." In interviews with the PSA Compliance Manager and Classification Supervisor it was indicated that information obtained from the assessment would be utilized to ensure the safety and wellbeing of the detainee; however, a review of the facility Initial PREA Assessment form confirms it does not consider whether the detainee has a physical disability, whether the detainee identifies as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In addition, interviews with booking staff indicated that should the assessment identify a victim or abuser a referral would be made to medical or mental health as appropriate; however, the assessment does not include whether the detainee identifies as transgender, intersex or gender nonconforming or the detainee's own concerns about his/her safety. In an interview with the Classification Supervisor, it was further confirmed that reassessments would be completed two times a year to evaluate safety concerns utilizing the Initial PREA Assessment form. In interviews with five random detention deputies, it was indicated should a transgender detainee want to shower separately from other detainees the opportunity exists. The facility did not provide documentation to confirm that the facility Initial PREA Assessment form was utilized to make decisions regarding a detainee's initial housing, recreation or other activities, and voluntary work. There were no transgender or intersex detainees housed at the facility during the on-site audit.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. A review of the facility Initial PREA Assessment form confirms it does not consider whether the detainee has a physical disability, whether the detainee identifies as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. In addition, the facility did not provide documentation to confirm that the facility Initial PREA Assessment form was utilized to make decisions regarding a detainee's initial housing, recreation or other activities, and voluntary work. In interviews with booking staff, it was indicated that should the assessment identify a victim or abuser a referral would be made to medical or mental health as appropriate; however, the assessment does not include whether the detainee identifies as transgender, intersex or gender nonconforming or the detainee's own concerns about his/her safety. To become compliant, the facility must implement a practice that requires the facility to consider whether the detainee had a physical disability, whether the detainee identified as transgender, intersex or gender nonconforming, or the detainee's own concerns about his/her safety. Once implemented, the facility must train all applicable staff on the new practice and document such training. In addition, the facility must establish and implement a procedure to ensure that information gained from the initial risk screening is considered when determining detainee housing, recreation and other activities, and voluntary programming and that medical and/or mental health staff are consulted when determining placement for transgender and intersex detainees. Once implemented, the facility must submit documentation that all applicable staff, including medical and mental health, are trained on the new procedure. In addition, the facility must submit 10 detainee files to confirm information gained from the initial risk assessment was considered in determining the detainee's housing, recreation and other activities, and voluntary work program. If applicable, the facility must submit to the Auditor all detainee files that include transgender or intersex detainees that were received during the CAP period.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): HCDC policy 3C-36, Special Management Units, mandates, "An inmate will be placed in "protective custody" status in Administrative Segregation only when there is documentation that it is warranted and that no reasonable alternatives are available" and "a member of Classification shall conduct a review within 72 hours of the inmate's placement in Administrative Segregation to determine whether segregation is still warranted. The review shall include an interview with the inmate. A written record shall be made of the decision and the justification." HDCD policy 3C-36 further states, "Generally, these inmates shall receive the same privileges as are available to inmates in the general population, depending on any safety and security considerations for inmates, facility staff and security." In addition, HCDC policy 3C-36 states, "Immigration Customs Enforcement (ICE Field Operating Director (FOD) will be contacted within 72 hours of placement in Administrative Segregation" and "a member of Classification shall conduct the same type of review after the inmate has spent 7 days in Administrative Segregation, and every week thereafter, for the first 60 days and (at least) every 30 days thereafter." A review of HCDC policy 3C-36 confirms it does not include the requirements to place detainees in Administrative Segregation for the least amount of time practicable and that such placement shall not ordinarily exceed 30 days. In addition, a review of HCDC policy 3C-36 confirms it does not require a supervisor to conduct a review within 72 hours of the detainee's placement in Administrative Segregation or after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter. The Auditor reviewed HCDC policy 3C-36 and could not confirm that the facility had developed the procedures in consultation with the ICE ERO FOD. The Auditor reviewed a blank Administrative/Disciplinary Segregation Placement/Review Form and confirmed the form has a line for a member of the assigning supervisor to sign and an area to mark "protective custody" as the reason for placement in administrative segregation; however, the form does not include an area to document that the detainee is being placed in Administrative Segregation on the basis of being vulnerable to sexual abuse or assault. A review of the Administrative/Disciplinary Segregation Placement/Review Form further

confirmed it does not include documentation that confirms the appropriate ICE FOD was notified no later than 72 hours after the initial placement into segregation was made or that the required reviews were conducted by a supervisor. In an interview with the PSA Compliance Manager and OIC it was indicated that detainees would be held in administrative segregation for the least amount of time; however, the PSA Compliance Manager could not articulate the timeframes required by the standard.

Does Not Meet (a)(b)(d)(e): The facility is not in compliance with subsections (a), (b), (d), and (e) of the standard. A review of HCDC policy 3C-36 confirms it does not include the requirements to place detainees in Administrative Segregation for the least amount of time practicable and that such placement shall not ordinarily exceed 30 days. In addition, a review of HCDC policy 3C-36 confirms it does not require a supervisor to conduct a review within 72 hours of the detainee's placement in Administrative Segregation or after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter. The Auditor reviewed HCDC policy 3C-36 and could not confirm that the facility had developed the procedures in consultation with the ICE ERO FOD. The Auditor reviewed a blank Administrative/Disciplinary Segregation Placement/Review Form and confirmed the form has a line for a member of the assigning supervisor to sign and an area to mark "protective custody" as the reason for placement in administrative segregation; however, the form does not include an area to document that the detainee is being placed in Administrative Segregation on the basis of being vulnerable to sexual abuse or assault. A review of the Administrative/Disciplinary Segregation Placement/Review Form further confirmed it does not include documentation that confirms the appropriate ICE FOD was notified no later than 72 hours after the initial placement into segregation was made or that the required reviews were conducted by a supervisor. To become compliant, the facility must, in consultation with the ERO FOD, update HCDC policy 3C-36 to include the requirements to place detainees in Administrative Segregation for the least amount of time practicable, that such placement shall not ordinarily exceed 30 days, and supervisory staff will conduct a review within 72 hours of a detainee's placement in administrative segregation, an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter. Once developed the facility must provide the Auditor with a copy of HCDC policy 3C-36 with documentation that the policy was updated in consultation with the ERO FOD. Once implemented the facility must train all security supervisors on the requirements of updated HCDC policy 3C-36 and provide the Auditor with documentation that confirms the training was received. If applicable, the facility must submit to the Auditor any detainee files that include a detainee being placed in protective custody due to being vulnerable to sexual abuse to confirm the reasons for placement were documented and that the ICE ERO FOD was notified within 72 hours of the initial placement in Administrative Segregation.

§115.51 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): HCDC policy 3C-21(a) mandates, "The facility provides multiple internal ways for inmates to-report easily, privately, and securely sexual abuse/harassment, retaliation by other inmates or staff for reporting sexual abuse/harassment, and staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse/harassment. The facility also provides at least one way for inmates to report the abuse/harassment to an outside public entity or office not affiliated with the agency that has agreed to receive reports and forward them to the facility head, except when an inmate requests confidentiality. Staff accepts reports made verbally, in writing, anonymously, and from third parties and immediately puts into writing any verbal reports." During the on-site tour the Auditor observed in housing units and the booking area the DHS-prescribed sexual abuse and assault awareness notice, the DHS-prescribed SAA Information pamphlet, the contact information for the DHS OIG and foreign consulate, in English and Spanish, and the HCDC zero-tolerance poster in English only. The Auditor reviewed the HCDC facility handbook and confirmed it did not list information on how a detainee could report retaliation or staff neglect or violations that may have contributed to such incidents or that detainees are allowed to report anonymously or specific instruction on avenues to report anonymously. A review of the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet confirms how to make an anonymous report of sexual abuse is included; however, the Auditor could not confirm that the ICE National Detainee Handbook or the DHS-prescribed SAA Information pamphlet is provided to all detainees in a manner they could understand. The Auditor was provided with a signed MOU with the Crisis Center of Grand Island and was able to confirm this organization would accept reports of sexual abuse; however, a review of the MOU further confirmed the Crisis Center of Grand Island would only release the victim's confidential information after receiving appropriate authorization from the victim thus hindering their abilities to immediately forward all reported allegations of sexual abuse or receive an anonymous report. During the on-site tour, the Auditor attempted to place calls to the telephone number included in the DHS-prescribed sexual abuse and assault awareness notice, the National Sexual Assault Hotline, the DHS OIG, and the Crisis Center of Grand Island from the housing unit telephones utilizing a generic PIN that can be utilized for each housing unit to make anonymous reports; however, when the Auditor attempted to call numbers utilizing the PIN, a voice recording was received stating, "Cannot respond, goodbye" or "Denied for account." In interviews with the PSA Compliance Manager and five detention deputies it was confirmed that all reports of sexual abuse made by a detainee verbally, in writing, anonymously, and through third parties would be accepted and all reports made verbally would be documented.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. A review of the MOU with the Crisis Center of Grand Island confirmed the Crisis Center of Grand Island would only release the victim's confidential information after receiving appropriate authorization from the victim thus hindering their abilities to immediately forward all reported allegations of sexual abuse or accept an anonymous report. During the on-site audit, the Auditor attempted to place calls to the telephone numbers included in the DHS-prescribed sexual abuse and assault awareness notice, the National Sexual Assault Hotline, the DHS OIG, and the Crisis Center of Grand Island from the housing unit telephones utilizing a generic PIN that can be utilized for each housing unit to make anonymous reports; however, when the Auditor attempted to call numbers utilizing the PIN, a voice recording was received stating,

"Cannot respond, goodbye" or "Denied for account." To become compliant, the facility must provide detainees at least one way to report an allegation to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request, including but not limited to, working telephones that enable a detainee to contact said outside entity. Once implemented, the facility must provide the Auditor with documentation that confirms the new procedure was implemented. In addition, the facility must provide documentation that facility telephones are in working order to allow detainees access to report an allegation of sexual abuse, retaliation for reporting an incident of sexual abuse, staff neglect, or violations of staff responsibilities that may have contributed to an incident to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): HCDC policy 51-02, Grievance Procedure, mandates, "Grievances involving immediate threats to the safety and/or security of an inmate shall be immediately expedited to the Shift Supervisor or designee for investigation. Inmates are not required to utilize any informal grievance process or to otherwise attempt to resolve with staff, an alleged incident of sexual assault/abuse. Initial responses to sexual assault/abuse grievances including sexual assault/abuse will be given within 48 hours with a completed final decision within 5 calendar days. The response will document the determination of whether the inmate is in substantial risk of immediate sexual abuse and the action taken in response to the grievance." HCDC policy 51-02 further states, "The final agency decision regarding the merits of any portion of the grievance alleging sexual abuse will be issued within 90 days of the initial filing of the grievance. Third party, fellow inmates, staff members, family members, attorneys and outside advocates may submit a grievance alleging sexual abuse on behalf of an inmate. The department may discipline an inmate for filing a grievance related to alleged sexual abuse only when the department demonstrates that the inmate filed the grievance in bad faith" and "no time lime limitations are placed on grievances alleging sexual abuse." In addition, HCDC policy 51-02 states, "Inmates may appeal their grievance response to the Assistant Director of Corrections within seventy-two hours of receiving their response." The Auditor reviewed HCDC policy 51-02 and confirmed it does not include the requirements to issue a decision on the grievance within five days of receipt or the facility shall respond to an appeal of a grievance related to sexual abuse within 30 days. HCDC policy 6B-05, Procedure in the Event of a Sexual Assault, mandates, "Any inmate that alleges he/she was a victim of a sexual assault will be immediately removed from their current housing location and taken to the medical area. The medical staff will treat any injuries requiring immediate attention but will not perform any routine examination procedures." HCDC Inmate/Detainee Handbook states in part "Inmates/detainees may request assistance from another inmate/detainee or staff member to assist them with the grievance process, the Department's response to a grievance will be returned in a timely manner and detainees may appeal a grievance to ICE. In interviews with the PSA Compliance Officer and Grievance Officer (GO) it could not be confirmed the facility sends all grievances related to sexual abuse and the facility decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. In an interview with the GO, it was indicated detainees are permitted to file a formal grievance related to sexual abuse at any time with no time limit imposed and that there are written procedures for handling time-sensitive grievances. In addition, the GO indicated medical emergencies are brought to the immediate attention of medical staff, decisions are issued on sexual abuse incidents within five days of receipt, and the facility OIC responds to an appeal of said grievances within 30 days. In an interview with the GO, it was further indicated that all grievances are sent through the CIDNET system and received almost instantaneously. In an interview with the PSA Compliance Manager, it was confirmed that HCDC does not impose a time limit for grievances related to sexual abuse. In interviews with five detention deputies and the GO it was indicated that medical grievances will be processed immediately and that should a detainee require the assistance of a third party to complete the grievance, one will be accommodated.

Recommendation (a)(b)(c)(d)(e)(f): It is recommended that the facility include additional grievance information in the facility inmate/detainee handbook to include timelines, who can provide assistance for detainees, and detailed instruction pertaining to filing a formal grievance related to sexual abuse.

Does Not Meet (e): The facility is not in compliance with subsections (e) and (f) of the standard. The Auditor reviewed HCDC policy 51-02 and confirmed it does not include the requirements to issue a decision on the grievance within five days of receipt or the facility shall respond to an appeal of a grievance related to sexual abuse within 30 days. In interviews with the PSA Compliance Officer and GO it could not be confirmed the facility sends all grievances related to sexual abuse and the facility decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. To become compliant, the facility must implement practices that requires the facility to issue a decision on a grievance related to sexual abuse within five days of receipt, to respond to an appeal of a grievance related to sexual abuse within 30 days, and to send all grievances related to sexual abuse and the facility decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. Once implemented the facility must document that all applicable staff have been trained on the new practices. If applicable, the facility is to submit to the Auditor copies of any time sensitive grievances that involve an immediate threat to detainee health, safety or welfare and related to sexual abuse occurring during the CAP period.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): HCDC policy 3C-21(a) mandates, "In addition to providing on-site mental health care services, the facility provides inmates with access to outside victim advocates for emotional support services related to sexual abuse/harassment. The facility provides such access by giving inmates the current mailing addresses and telephone numbers, including toll-free hotline numbers, of

local, State, and/or national victim advocacy or rape crisis organizations and enabling reasonable communication between inmates and these organizations. The facility ensures that communications with such advocates are private, confidential, and privileged, to the extent allowable by Federal, State, and local law." HCDC policy 3C-21(a) further states, "The facility informs inmates, prior to giving them access, of the extent to which such communications will be private, confidential, and/or privileged. The Auditor reviewed a MOU between the facility and Crisis Center of Grand Island and confirmed the Crisis Center of Grand Island would provide confidential emotional support services and crisis intervention; however, the verbiage in the MOU does not confirm the Crisis Center of Grand Island would provide investigation and the prosecution of sexual abuse perpetrators to most appropriately address victims' needs. During the on-site audit the Auditor observed the HDCD zero-tolerance poster and confirmed it included the contact information for the Crisis Center of Grand Island; however, the poster did not include the extent to which the detainee phone calls to the center would be monitored or the extent to which reports of abuse would be forwarded to the authorities in accordance with mandatory reporting laws. In addition, the Auditor reviewed the facility handbook and confirmed it advises the detainee the extent to which phone calls would be monitored; however, it does not advise the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. During the on-site tour the Auditor observed the HDCD zero-tolerance poster and confirmed it included the contact information for the Crisis Center of Grand Island; however, the poster did not include the extent to which the detainee phone call to the center would be monitored or the extent to which reports of abuse would be forwarded to the authorities in accordance with mandatory reporting laws. In addition, the Auditor reviewed the facility handbook and confirmed it advises the detainee the extent to which phone calls would be monitored; however, it does not advise the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. To become compliant, the facility must provide to the Auditor documentation that the facility notified the detainee population the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory laws in a manner that all detainees could understand, including but not limited to, those detainees who speak a language other than English or Spanish.

§115.54 - Third-party reporting.

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

Notes:

HCDC policy 3C-21(a) mandates, "The facility receives and investigates all third-party reports of sexual abuse/harassment" and "the facility distributes publicly information on how to report sexual abuse/harassment on behalf of an inmate. The Auditor reviewed HCDC's website, www.hallcountyne.gov/content.lasso?page=7497& and confirmed it contains three different avenues for third party reporting. In addition, the Auditor reviewed the ICE web page (https://www.ice.gov) and confirmed it provides a means for the public to report incidents of sexual abuse/harassment on behalf of any detainee. The Auditor reviewed the facility handbook and confirmed it does not contain information on how a detainee can make a third-party report of sexual abuse. In interviews with six detainees, it was indicated that none of the detainees interviewed were aware of how to make a third-party report of sexual abuse.

Recommendation: The Auditor recommends the facility update the facility handbook to include information on how the detainee can make a third-party report of sexual abuse.

§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)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." HCDC policy 3C-21(a) mandates, "All staff members are required to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse/harassment that occurred in an institutional setting; retaliation against inmates or staff who reported abuse/harassment; and any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse/harassment or retaliation. Reporting will be done within the chain of command or outside of the chain of command. This may include other law enforcement agencies, depending on staff involvement. Apart from reporting to designated supervisors or officials, staff must not reveal any information related to a sexual abuse/harassment report to anyone other than those who need to know, as specified in agency policy, to make treatment, investigation, and other security and management decisions. Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners are required to report sexual abuse/harassment and must inform inmates of their duty to report at the initiation of services. If the victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the facility head must report the allegation to the designated State or local services agency under applicable mandatory reporting laws." A review of HCDC policy 3C-21(a) and an interview with the In SDDO confirmed the policy was reviewed and approved by the Agency. In an interview with the OIC and PSA Compliance Manager it was indicated that in addition to making a report of sexual abuse involving a vulnerable adult as required by State and local vulnerable persons statutes they would also report the incident to the Agency. In interviews with the PSA Compliance Manager, classification officer, and five detention deputies it was

confirmed that reports of sexual abuse would be reported immediately and that they would not reveal any information to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation law enforcement or other security and management decisions. In addition, in interviews with five detention deputies if was indicated that they were aware they could report incidents of sexual abuse outside of their organization and gave examples such as the District Attorney's office or representative for the employee organization. The facility does not house juvenile detainees.

§115.62 - Protection duties.

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

Notes:

HCDC policy 3C-21(a) mandates, "Staff shall take seriously all statements from inmates claiming to be victims of sexual assaults and shall respond supportively and non-judgmentally. Any inmate who alleges that they have been sexually assaulted shall be offered immediate protection from the assailant and shall be referred for a medical examination and/or clinical assessment for potential negative symptoms. Staff members who become aware of an alleged assault shall immediately follow the reporting requirements set forth in the written policies and procedures." The Auditor reviewed two investigation files; however, neither allegation indicated that either detainee was subject to substantial risk of imminent sexual abuse. In interviews with the PSA Compliance Manager, classification officer, five detention deputies, and booking staff it was indicated should staff become aware of any substantial risk of imminent sexual abuse the detainee would be removed from the situation immediately.

§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): HCDC policy 3C-21(a) mandates, "When the facility receives an allegation that an inmate was sexually abuse/harassment while confined at another facility, the head of the facility where the report was made notifies in writing the head of the facility where the alleged abuse/harassment occurred. The head of the facility where the alleged abuse/harassment occurred ensures the allegation is investigated. Notification will be made as soon as possible, but no 72 hours after receiving the allegations. The notification will be documented." In an interview with the PSA Compliance Manager, it was confirmed that should HCDC receive information that a detainee was sexually abused at another facility notifications would be made to the PSA Compliance Manager who in turn would notify the facility where the abuse occurred and the ICE FOD within 72 hours. In addition, the PSA Compliance Manager indicated the notification would be documented by email and should a detainee be transferred and HCDC notified of an allegation that happened at their facility, the FOD would be notified and an investigation would be initiated immediately upon being notified. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither allegation included a detainee from another facility who reported an allegation of sexual abuse to staff at HCDC or reported an allegation of sexual abuse at another facility while housed at HCDC.

§115.64 - Responder duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): HCDC policy 3C-21(a) mandates, "Upon learning that an inmate was sexually abused within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report is required to separate the alleged victim and abuser; seal and preserve any crime scene(s); instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder non-security staff member, he or she is required to instruct the victim not to take any actions that could destroy physical evidence and then notify security staff." Interviews with five detention deputies, booking, and classification staff confirmed that they were knowledgeable regarding their duties as a first responder with the exception of the standard's requirement to request the victim not take actions and ensure the alleged abuser does not take actions to destroy evidence.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. A review of HCDC policy 3C-21(a) requires security first responders and non-security first responders instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. In addition, a review of HCDC policy 3C-21(a) confirms it does not include the requirement that security first responders ensure the alleged abuser does not take actions to destroy evidence. In interviews with five detention deputies, booking, and classification staff indicated they could not articulate the standards requirement to request the victim not take actions and ensure the alleged abuser does not take actions to destroy evidence. To become compliant, the facility must update HCDC policy 3C-21 to include the requirements that security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating and to ensure the alleged abuser does not take actions to destroy evidence. In addition, the facility must update HCDC policy 3C-21(a) to include the requirement that non-security first responders request the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. Once updated the facility must train all security first responders and non-security first responders on the updated policy. If applicable the facility must submit to the Auditor all sexual abuse allegation investigation files that occur during the CAP period.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): The facility submitted HCDC policy 3C-21(a) as their Coordinated Response Plan. HCDC policy 3C-21(a) mandates, "Upon learning that an inmate was sexually abused within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report is required to separate the alleged victim and abuser; seal and preserve any crime scene(s); instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder non-security staff member, he or she is required to instruct the victim not to take any actions that could destroy physical evidence and then notify security staff. All actions taken in response to.an incident of sexual abuse/harassment are coordinated among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The facility's coordinated response ensures that victims receive all necessary immediate and ongoing medical, mental health, and support services and that investigators are able to obtain usable evidence to substantiate allegations and hold perpetrators accountable." A review of HCDC policy 3C-21(a) confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. In addition, a review of HCDC policy 3C-21(a) confirms it requires security first responders and non-security first responders instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. In interviews with five detention deputies, booking and classification staff it was indicated they could not articulate the requirement to request the detainee victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. A review of HDCD policy 3C-21(a) further confirms it does not include the required verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The Auditor reviewed two allegations of sexual abuse investigation allegations and confirmed neither included a detainee who was transferred due to an incident of sexual abuse.

Does Not Meet (a)(c)(d): The facility is not in compliance with subsections (a), (c) and (d) of the standard. A review of HCDC policy 3C-21(a), which serves as the facility's coordinated response plan, confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. In addition, HCDC policy 3C-21(a) a review of HCDC 3C-21(a) confirms it requires security first responders and non-security first responders instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. A review of HDCD policy 3C-21(a) further confirms it does not include the required verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." In interviews with five detention deputies, booking, and classification staff it was indicated they could not articulate the requirement to request the detainee victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. To become compliant, the facility must update HCDC policy 3C-21(a) to include the coordinated actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse, and to include the requirements security first responders to request detainee the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating and to ensure the alleged abuser does not take actions to destroy evidence and non-security first responders request detainee the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. In addition, the facility must update HCDC policy 3C-21(a) to include the verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." Once implemented the facility must document that all applicable staff, including medical, have been trained on the updated procedure. If applicable, the facility must submit all sexual abuse allegation investigation files that occur during the CAP 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:

HCDC policy 3C-21(a) mandates, "The agency protects all inmates and staff who report sexual abuse/harassment or cooperate with sexual abuse/harassment investigations from retaliation by other inmates or staff. The agency employs multiple protection measures, including 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/harassment or cooperating with investigations." Interviews with the OIC and PSA Compliance Manager indicated staff members, contractors, or volunteers would be reassigned or placed on administrative leave depending on the severity of the alleged action and that the facility would also

consider whether to prohibit further contact with inmates, termination of services and/or contracts, after a sustained finding after an allegation of sexual abuse.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Agency policy 11062.2 mandates, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." HCDC 3C-21(a) mandates, "The agency protects all inmates and staff who report sexual abuse/harassment or cooperate with sexual abuse/harassment investigations from retaliation by other inmates or staff. The agency employs multiple protection measures, including 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/harassment or cooperating with investigations. The agency monitors the conduct and/or treatment of inmates or staff who have reported sexual abuse/harassment or cooperated with investigations, including any staff reassignments, negative staff performance reviews, inmate disciplinary reports, housing, or program changes, for at least 90 days (or longer if needed) following their report or cooperation to see if there are changes that may suggest possible retaliation by inmates or staff. The agency discusses any changes with the appropriate inmate or staff member as part of its efforts to determine if retaliation is taking place and, when confirmed, immediately takes steps to protect the inmate or staff member. Monitoring shall include periodic welfare checks. This is monitored by the PREA Coordinator." In an interview with the PSA Compliance Manager, it was indicated detainees do not program at HCDC; however, they would be monitored to include housing and disciplinary reports. The Auditor reviewed two sexual abuse allegation investigation files and confirmed there was no documentation to confirm either detainee was monitored following their report of sexual abuse.

Does Not Meet (c): The facility is not in compliance with subsection (c) of this standard. Although there were two allegations reported during the audit period, the facility did not submit any documentation that confirmed retaliation monitoring was conducted for either case. To become compliant, the facility must provide documentation that confirms retaliation monitoring was conducted for both detainees who reported an incident of sexual abuse. If documentation does not exist, the facility must provide documentation that staff responsible for detainee and staff monitoring following an incident of sexual abuse have been trained on the standards requirements. If applicable, the facility must provide the Auditor with all sexual abuse allegation investigation files and the corresponding monitoring documentation the occurred during the CAP period.

§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): HCDC policy 3C-21 mandates, "Care shall be taken to place the inmate in a supportive environment that represents the least restrictive housing option possible (e.g., protective custody). However, victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the inmate." HCDC policy 3C-36 states, "Immigration Customs Enforcement (ICE Field Operating Director (FOD) will be contacted within 72 hours of placement in Administrative Segregation." In addition, HCDC policy 3C-36 states, "If placement is longer than 5 days, will be reviewed whether placement is justified by extraordinary circumstances or is at the detainee's request. When a detainee has been in Administrative Segregation for more than 30 days, the Director of Corrections or designee shall notify ICE/DRO. When a detainee is held in Administrative Segregation for more than 60 days, the Director of Corrections or designee shall notify ICE/ERO. ICE/ERO shall then consider whether it would be appropriate to transfer the detainee to a facility where he/she may be placed in the general population." HCDC 3C-22, Classification/Re-housing states, "An inmate/detainee in administrative segregation due to sexual abuse and is being rehoused to general population a PREA reassessment will be completed." In interviews with the PSA and OIC it was indicated that detainees would be held in administrative segregation for the least amount of time and that placement would not exceed five days. There were no detainees placed in protective custody at HCDC due to an allegation of sexual abuse during the audit period.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f): HCDC policy 3C-21(a) mandates, "Agency investigations into allegations of sexual abuse/harassment are prompt, thorough, objective, and conducted by investigators who have received special training in sexual abuse/harassment investigations. When outside agencies investigate sexual abuse/harassment, the facility has a duty to keep abreast of the investigation and cooperate with outside investigators. Investigations include the following element: Investigations are initiated and completed within the timeframes established by the highest-ranking facility official, and the highest-ranking official approves the final investigative report. Investigators gather direct and circumstantial evidence, including any available physical and DNA evidence and any electronic monitoring data; interview alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse/harassment involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, prosecutors are contacted to determine whether compelled interviews may be an obstacle for subsequent criminal prosecution. Investigative findings are based on an analysis of the evidence gathered and a determination of its probative value. The credibility of a victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as inmate or staff. The Department will not allow the inmate to submit to a polygraph examination. Investigations include an effort to determine whether staff negligence or collusion enabled the abuse/harassment to occur. Administrative investigations are documented in written reports that include a description of the physical and testimonial evidence and the reasoning behind credibility assessments. Criminal

investigations are documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and provides a proposed list of exhibits. The Department retains all written reports as long as the alleged abuser is incarcerated or employed by Department plus five years. Copies of all documentary evidence will be given to criminal investigators when feasible. Substantiated allegations of conduct that appears to be criminal are referred for prosecution." A review of HCDC policy 3C-21 and an interview with the facility SDDO confirmed HCDC policy 3C-21 was reviewed and approved by the Agency. A review of HCDC policy 3C-21 confirms it does not include the verbiage "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." In addition, a review of HCDC policy 3C-21(a) confirms it does not govern the coordination and sequencing of the two types of investigations in accordance with subsection (b) of the standard to ensure that the criminal investigation is not compromised by the internal administrative investigation or to continue the investigation should the alleged abuser or detainee victim depart from the employment or control of the facility. In an interview with a facility Investigator, it was indicated that the investigation would continue even if the alleged abuser or victim was no longer at the facility. The facility Investigator further indicated that should an outside agency investigate the case; evidence would be provided to support the case and he would remain in contact through emails or telephone calls regarding the status of the case. The Auditor was provided with certificates of completion from the National Institute of Corrections for the course: PREA: Investigating Sexual Abuse in a Confinement Setting for all facility Investigators. The Auditor reviewed the training curriculum and confirmed it included all elements required by the standard. The Auditor reviewed two sexual abuse allegation investigation files and confirmed the investigations were completed promptly, thoroughly, and objectively.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. A review of HCDC policy 3C-21(a) confirms it does not include the verbiage "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate or administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." In addition, a review of HCDC policy 3C-21(a) confirms it does not govern the coordination and sequencing of the two types of investigations in accordance with subsection (b) of the standard to ensure that the criminal investigation is not compromised by the internal administrative investigation or to continue the investigation should the alleged abuser or detainee victim depart from the employment or control of the facility. To become compliant, the facility must update HCDC policy 3C-21(a) to include the verbiage "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate and administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." In addition, the facility must update HCDC policy 3C-21(a) to govern the coordination and sequencing of the two types of investigations in accordance with subsection (b) of the standard to ensure that the criminal investigation is not compromised by the internal administrative investigation or to continue the investigation should the alleged abuser or detainee victim depart from the employment or control of the facility. Once updated the facility must resubmit HCDC policy 3C-21(a) to the Agency for review and approval. In addition, the facility must train all applicable staff, including all facility Investigators, on the updated written procedures. If applicable, the facility must submit to the Auditor all sexual abuse allegation investigation files that occurred during the CAP period.

§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:

HCDC policy 3C-21(a) mandates, "Evidence standard for administrative investigations of sexual abuse/harassment are substantiated if supported by a preponderance of the evidence." In an interview with the PSA Compliance Manager, who serves as a facility Investigator, it was indicated when determining the outcome of an administrative investigation there is no other standard of evidence utilized except for preponderance of the evidence. The Auditor reviewed two sexual abuse allegation investigation files and confirmed a preponderance of evidence was the standard utilized to determine the investigation outcomes.

§115.73 - Reporting to detainees.

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

Notes:

HCDC policy 3C-21(a) mandates, "Following an investigation into an inmate's allegation that he or she suffered sexual abuse in the facility, the Department shall inform the inmate as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. If the Department did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the inmate." HCDC policy 3C-21(a) further states, "All such notifications or attempted notifications shall be documented. The Department's obligation to report shall be terminated if the inmate is released from the custody." Review of this policy did note conflicting statements regarding notification to the detainee. The Auditor reviewed two sexual abuse allegation investigation files and confirmed the detainee victim was notified as to the determined outcome in both files.

§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): HCDC policy 3C-21(a) mandates, "Staff is subject to disciplinary sanctions up to and including termination when staff has violated agency sexual abuse/harassment policies. The presumptive disciplinary sanction for staff members who have engaged in sexually abusive contact or penetration is termination. This presumption does not limit agency discretion to impose termination for other sexual abuse/harassment policy violations. All terminations for violations of agency sexual abuse/harassment policies are to be reported to law enforcement agencies and any relevant licensing bodies. Disciplinary sanctions for violations of agency policies relating to the sexual abuse/harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse/harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies." A review of HCDC policy 3C-21(a) confirms it does not contain the verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" or "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." However, as termination is greater than removal from Federal Service, the Auditor finds HCDC policy 3C-21(a) in substantial compliance with the wording required by subsection (b) of the standard. In an interview with the OIC it was confirmed that staff would be subject to disciplinary or adverse action including termination for substantiated allegations of sexual abuse and that the appropriate notifications would be made to any law enforcement or relevant licensing bodies as required. The Auditor reviewed one sexual abuse allegation investigation file that included a staff-on-detainee and confirmed the determined outcome to be unsubstantiated.

§115.77 - Corrective action for contractors and volunteers.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): HCDC policy 3C-21(a) mandates, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." Further review of HCDC policy 3C-21(a) confirms it does not require that the facility make reasonable efforts to report to any relevant licensing body, to the extend known, incidents of substantiated abuse by a contractor or volunteer. In an interview with the OIC it was confirmed that contractors or volunteers would have their security clearance revoked and not allowed to enter the facility; however, the interview could not confirm the facility would make reasonable efforts to report to any relevant licensing body, to the extend known, an incident of substantiated abuse by a contractor or volunteer.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of HCDC policy 3C-21(a) confirms it does not require that the facility make reasonable efforts to report to any relevant licensing body, to the extend known, incidents of substantiated abuse by a contractor or volunteer. In an interview with the OIC, it was confirmed that contractors or volunteers would have their security clearance revoked and not allowed to enter the facility; however, the interview could not confirm the facility make reasonable efforts to report to any relevant licensing body, to the extend known, an incident of substantiated abuse by a contractor or volunteer. To become compliant, the facility must implement a practice the requires the facility make reasonable efforts to report to any relevant licensing body, to the extent known, an incident of substantiated abuse by a contractor or volunteer. In addition, the facility must train all applicable staff on the updated practice. If applicable, the facility must submit all sexual abuse allegation investigation files that occurred during the CAP period that include facility volunteers or contractors.

§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): HCDC policy 3C-21(a) mandates, "Inmates shall be subject to disciplinary sanctions pursuant to a 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. Sanctions shall be commensurate with the nature of the circumstances of the abuse committed, the inmate's disciplinary history, and the sanctions imposed for comparable offenses by other inmates with similar histories. The disciplinary process shall 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. When possible, therapy, counseling, and other interventions designed to address and correct underlying reasons or motivations for the abuse, the Department shall consider whether to require the offending inmate to participate in such interventions as a condition of access to programming or other benefits. The Department may discipline an inmate for sexual contact with staff only upon a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The department prohibits all sexual activity between inmates and may discipline inmates for such activity. The Department may not, however, deem such activity to constitute sexual abuse of it determines the activity is not coerced." The Auditor reviewed the facility handbook and confirmed rule 309 is a disciplinary infraction for "An inmate subjects a victim to unwanted sexual contact; or an inmate participates in a consensual sexual activity involving touching of intimate parts or penetration." Further review of the handbook confirms it lists the progressive disciplinary steps with reviews and appeals afforded to the detainee. In an interview with the PSA Compliance Manager, it was indicated the facility follows a formal disciplinary

process. The Auditor reviewed two sexual abuse allegation investigation files and confirmed one case included a detainee-on-detainee; however, the determined outcome was unsubstantiated.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): HCDC policy 3C-21(a) mandates, "Qualified medical or mental health practitioners ask inmates about prior sexual victimization and abusiveness during medical and mental health reception and intake screenings. If an inmate discloses prior sexual victimization or abusiveness, whether it occurred in an institutional setting or in the community, during a medical or mental health reception or intake screening, the practitioner provides the appropriate referral for treatment, based on his or her professional judgment. Any necessary referrals and/or follow up meetings shall be done within 14 days." In an interview with a facility RN it was confirmed the facility's two staff positions for mental health workers were not filled at the time of the on-site audit and if a mental health referral was needed medical would send the referral via email to be processed when a mental health worker was at the facility.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. A review of HCDC policy 3C-21(a) confirms that should information become known that the detainee has experienced prior sexual victimization or perpetrated sexual abuse staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow up and that such referrals and follow ups will be done within 14 days. Subsections (b) and (c) require a medical follow-up within 48 hours of the referral and a mental health follow-up within 72 hours of the referral. To become compliant, the facility must develop and implement a practice that requires all detainees referred to medical be seen within 48 hours of the referral and if referred to mental health be seen within 72 hours of the referral as required by subsection (c) of the standard. Once implemented, the facility must submit documentation that all medical and mental health staff have been trained on the new practice. If applicable, the facility must submit to the Auditor any intake, medical, and mental health records of any detainee, who pursuant to §115.41 indicates they have experienced prior sexual victimization or perpetrated sexual abuse during the CAP period.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): HCDC policy 3C-21(a) mandates, "Victims of sexual abuse have timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. Treatment services must be provided free of charge to the victim and regardless of whether the victim names the abuser. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders take preliminary steps to protect the victim and immediately notify the appropriate medical and mental health practitioners." A review of HCDC policy 3C-21 confirms it does not include the requirements to provide emergency contraception or to provide sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. In an interview with a facility RN, it was indicated any detainee alleging sexual abuse and in need of emergency care would be taken to (CHI) Health St. Francis. The Auditor reviewed a signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed the detainee would be provided immediate medical care; however, the MOU does not confirm that (CHI) St. Francis would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, the Auditor reviewed a MOU with the Crisis Center of Grand Island and confirmed the Crisis Center has agreed to provide crisis intervention services to detainee victims of sexual abuse. In interviews with the PSA Compliance Manager, five detention deputies, and two custody first responders it was indicated medical treatment would be immediate for any detainee victim of sexual abuse. In addition, the PSA Compliance Manager indicated that medical services would be timely and free of charge; however, no documentation was received to confirm the services would be provided immediately and free of charge. During the on-site audit, The Auditor reviewed two sexual abuse allegation investigation files and confirmed a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of HCDC policy 3C-21 confirms it does not include the requirements to provide emergency contraception or to provide sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The Auditor reviewed of a signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed the detainee would be provided immediate medical care; however, the MOU does not confirm that the care would include (CHI) Health St. Francis would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. During the on-site audit, the Auditor reviewed two sexual abuse allegation investigation files and could only confirm a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse. To become compliant, the facility must provide documentation that confirms detainee victims of sexual abuse are provided with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The facility must provide documented training to all applicable staff regarding their responsibility to provide the

detainee victim with all requirements of the standard. If applicable, the facility must provide the Auditor with any sexual abuse allegation investigative files that occurred during the CAP period.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f)(g): HCDC policy 3C-21(a) mandates, "The facility provides ongoing medical and/or mental health evaluation and treatment to all known victims of sexual abuse. The evaluation and treatment of sexual abuse victims must include appropriate follow-up services, treatment plans, and, when necessary, referrals for continued care following their release from custody. The level of medical and mental health care provided to inmate victims must match the community level of care generally accepted by the medical and mental health professional communities. The facility conducts a mental health evaluation of all known abusers and provides treatment, as deemed necessary by qualified mental health practitioners." HCDC policy 3C-21 further mandates, "Inmate victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. If pregnancy results from the abuse, such victim shall receive timely and comprehensive information about lawful pregnancy-related medical services." In addition, HCDC policy 3C-21(a) mandates, "Treatment services must be provided free of charge to the victim and regardless of whether the victim names the abuser." A review of HCDC policy 3C-21(a) confirms it does not require the facility provide detainee victims of sexual abuse with a pregnancy test, timely and comprehensive information about lawful pregnancy-related medical services, timely and lawful pregnancy-related medical services, tests for sexually transmitted infections as medically appropriate, or treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The Auditor reviewed a signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed a detainee victim of sexual abuse would be provided immediate medical care; however, the MOU does not confirm that the care (CHI) St. Francis would provide detainee victims of sexual abuse with included emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In an interview with the PSA Compliance Manager it was confirmed during the on-site audit there were two mental health positions that were not filled. In an interview with the facility RN it could not be confirmed how the facility would provide the detainee with the mental health services required by subsections (a), (b), (c), and (g) of the standard. During the on-site audit, The Auditor reviewed two sexual abuse allegation investigation files and confirmed a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse.

Does Not Meet (a)(b)(c)(e)(f)(g): The facility is not in compliance with subsections (a), (b), (c), (e), (f), and (g) of the standard. A review of HCDC policy 3C-21(a) confirms it does not require the facility provide detainee victims of sexual abuse with a pregnancy test, timely and comprehensive information about lawful pregnancy-related medical services, timely and lawful pregnancy-related medical services, tests for sexually transmitted infections as medically appropriate, or medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In an interview with the facility RN, it was indicated any detainee victim of sexual abuse in need of medical treatment would be taken to (CHI) Health St. Francis. The Auditor reviewed a signed MOU with the Director of Emergency Services of (CHI) Health St. Francis and confirmed a detainee victim of sexual abuse would be provided immediate medical care; however, the MOU does not confirm that the care (CHI) St. Francis would provide detainee victims of sexual abuse with included a pregnancy test, timely and comprehensive information about lawful pregnancy-related medical services, timely and lawful pregnancy-related medical services, tests for sexually transmitted infections as medically appropriate, or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse, emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care or that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In an interview with the PSA Compliance Manager, it was confirmed during the on-site audit there were two mental health positions that were not filled. In an interview with the facility RN, it could not be confirmed how the facility would provide the detainee with the mental health services required by subsections (a), (b), (c), and (g) of the standard. The Auditor reviewed two sexual abuse allegation investigation files and confirmed a Mental Health Assessment form was completed for one of the detainees who reported an allegation of sexual abuse. To become compliant, the facility must provide documentation that confirms detainee victims of sexual abuse are provided with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and that medical treatment services would be provided to the victim without financial cost and regardless of whether the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, the facility must provide documentation that confirms mental health staff are available to provide the detainee victim of sexual abuse with all required elements of subsections (a), (b), (c), (e), (f), and (g) of the standard. The facility must provide documented training of all applicable staff, including medical and mental health, regarding their responsibility to provide the detainee victims of sexual abuse with all requirements of the standard. If applicable, the facility must provide the Auditor with any sexual abuse allegation investigative files that occurred during the CAP period. If applicable, the facility must provide the detainee files, including medical and mental health of any known detainee-on-detainee abusers housed at HCDC during the CAP period.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): HCDC policy 3C-21(a) mandates, "The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review shall ordinarily occur within 30 days of the conclusion of the investigation. The review team shall include administrative officials, with input from supervisors, investigators, and medical or mental health practitioners. The review team shall…Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility…" In addition, HCDC policy 3C-21(a) states, "Prepare a report of its findings, including but not limited to determinations made and any recommendations for improvement and submit such report to the Director and PREA Coordinator. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so." The Auditor reviewed a PREA Review Committee memorandum stating in part that it was conducting a 30-day review as mandated in policy and upholding the final determination of the allegation; however, the memo only indicated that the review team agrees with the unsubstantiated finding and could not confirm that they took into consideration whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, a review of the submitted incident review could not confirm that the report and the review were submitted to the Agency PSA Coordinator. Interviews with the facility PSA Compliance Manager could not confirm the facility would conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation including where the allegation has been determined to be unfounded. In addition, interviews with the PSA Compliance Manager could not confirm the review team would consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, a report of its findings would be prepared including the determinations made and any recommendations for improvement, or the report and response is submitted to the Agency PSA Coordinator. The Auditor reviewed the HCDC annual report for 2022 and could not confirm the report included detainees or that the report included a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. In addition, a review of the annual report could not confirm that either was submitted to the facility administrator, the FOD, or the Agency PSA Coordinator.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b) and (c) of the standard. A review of HCDC policy C3-21(a) confirms it does not require the facility to conduct a sexual abuse incident review at the conclusion of unfounded allegations of sexual abuse. The Auditor reviewed a PREA Review Committee memorandum stating in part that it was conducting a 30-day review as mandated in policy and upholding the final determination of the allegation; however, the memo only indicated that the review team agrees with the unsubstantiated finding and could not confirm that they took into consideration whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, a review of the submitted incident review could not confirm that the report and the review were submitted to the Agency PSA Coordinator. The Auditor reviewed the HCDC annual report for 2022 and could not confirm the report included detainees or that the report included a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. In addition, a review of the annual report could not confirm that either was submitted to the facility administrator, the FOD, or the Agency PSA Coordinator. To become compliant, the facility must implement a practice that requires the review of all sexual abuse allegation investigations including those that are determined to be unfounded and to submit all reports and incident reviews to the Agency PSA Coordinator upon completion of the review. The facility must train all review team members on the standards requirement to consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender; or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility must implement a practice that includes detainee incidents of sexual abuse on the annual report and that the report includes a review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. In addition, the facility must document that the annual report for 2022 has been submitted to the facility administrator, the FOD, and the Agency PSA Coordinator.

§115.87 - Data collection.

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

Notes:

(a): HCDC policy 3C-21(a) mandates, ""The agency ensures that the collected sexual abuse/harassment data are properly stored, securely retained, and protected. The agency makes all aggregated sexual abuse/harassment data, from facilities under its direct control and those with which it contracts…" In an interview with the PSA Compliance Manager it was indicated that files are kept for at least 10 years following the initial collection. During the on-site audit the Auditor observed case records are kept within the jail computer system and hard copy documents are kept in a locked cabinet.

§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)(e)(i)(j): The Auditor was able to observe all areas of the audited facility. All policies, memorandums, staff files, records and other relevant documentation was provided for review to complete a thorough audit. Audit notice signs were posted throughout the facility

in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor was allowed to interview detainees in private. The Auditor did not receive correspondence from any detainee, staff or outside entity prior to the on-site review.

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:	0
Number of standards met:	14
Number of standards not met:	25
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.

Jodi Upshaw 4/29/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 4/30/2023

Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 5/2/2023

Program Manager's Signature & Date