PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	8/3/2021	**To:**	8/5/2021
AUDITOR INFORMATION			
Name of auditor:	Douglas K. Sproat, Jr.	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Houston Field Office
Field Office Director:	Daniel Bible
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	126 Northpoint Drive
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:	IAH Secure Adult Detention Facility		
Physical address:	3400 FM 350 South, Livingston, Texas 77351		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	936-967-8000		
Facility type:	IGSA		
PREA Incorporation Date:	9/23/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	936-967-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	936.967-

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the IAH Secure Adult Detention Facility (IAH) (also known as Polk) was conducted on August 3-5, 2021, by U. S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor Douglas K. Sproat employed by Creative Corrections, LLC. The purpose of the audit was to determine compliance with the DHS PREA standards. This facility is operated by Management & Training Corporation (MTC) and contracted by U. S. Immigration and Customs Enforcement (ICE) for the housing of adult male detainees to hold and process individuals who are awaiting the results of a judicial removal review. This was the second DHS PREA audit of the facility. The audit period was August 5, 2020-August 5, 2021. Within this audit period, there were no investigative files to review; therefore, the investigative file review and some related standards where investigative files were used to support compliance were extended back to the facility's last audit date as the initial audit period. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C), and Assistant ICE PREA Program Managers (APM), (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) all DOJ- and DHS-certified PREA auditors. The role of the Program Manager is to provide oversight for the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. Due to unforeseen circumstances, this audit report was finalized by APM, (b) (6), (b) (7)(C).

IAH is located in Livingston, Texas, which is about 75 miles northeast of Houston, Texas. Its physical address is 3400 FM 350 South, Livingston. The facility is situated within two secure perimeter fences; there is a sterile zone between the fences with a shaker and a microwave system and razor ribbon at the top and bottom of the fences. The facility provides secure detention for medium and high custody adult male detainees. On the first day of the audit, the facility held 605 adult male detainees. The design capacity of the facility is 1,054 detainees. During the previous 12 months, 2,087 detainees were booked into IAH; the average time in custody at the facility is 26.35 days. According to the Pre-Audit Questionnaire (PAQ), the countries most often represented by the detainees are Cuba, Nicaragua, and Brazil.

About five weeks before the audit, ERAU Team Lead for the audit, (b) (6), (b) (7)(C) provided the Auditor with the facility's PAQ, facility policies, and other pertinent documents. The documentation was provided through ICE SharePoint. The various documents were compiled and organized in accordance with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form and arranged within folders for ease of auditing.

The first day of the audit began with an entry briefing. The ERAU Team Lead present on-site, Kay Washington, opened the briefing at 8:15 A.M. In attendance were:

- (b) (6), (b) (7)(C) Inspections and Compliance Specialist (ICS), ICE/ OPR/ERAU
- Alexander Sanchez, Warden, MTC
- (b) (6), (b) (7)(C) Prevention of Sexual Abuse (PSA) Compliance Manager, MTC
- (b) (6), (b) (7)(C) Detention Service Manager (DSM), ICE/Enforcement and Removal Operations (ERO)/CM
- (b) (6), (b) (7)(C) Deputy Warden (DW), MTC
- (b) (6), (b) (7)(C) Chief of Security (COS), MTC
- (b) (6), (b) (7)(C) Certified DOJ/DHS PREA Auditor, Creative Corrections, LLC.

After a brief round of introductions, the Team Lead provided a detailed schedule for the audit. The Auditor then gave an overview of the audit process and methodology used to establish PREA compliance. He explained that the process is designed for accurately evaluating the facility's written policies and procedures for compliance with PREA requirements, along with determining the degree to which these policies and procedures are a part of the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with PREA standards will be determined based on the review of policies and procedures, observations made during the facility tour, documents reviewed (both through ICE SharePoint and while on-site), and interviews with staff, contractors, and detainees. The Auditor advised the group that he had not received any correspondence from either detainees or staff. Just prior to the tour, the Auditor noted that the tour needed to cover all areas that the detainees had access to.

All areas of the facility that the detainees might access were covered: the sallyport, intake, medical, programs, recreation (indoor and outdoor), food service, law/leisure library, chapel, warehouse, laundry, commissary, visitation, and housing units. IAH is comprised of a single large building which houses all the facility's operations. The detainee housing portion of the building has 106 single occupancy cells, 71 8-man cells, and 16 24-man dorms. There are 22 segregation cells, 5 infirmary beds, and 1 mental health bed. The building also contains all the administrative functions and all support services. The single entrance for staff and visitors at IAH is through the part of the building that contains all administrative offices, central control, and visitation. In the lobby/reception area of this building, everyone, staff and visitors alike, sends all belongings (purses, briefcases, coats, etc.) though an X-ray machine, and everyone steps through a metal detector. An officer uses a wand for anyone who sets off the metal detector.

During the tour the Auditor observed the program/service areas, housing units and their showers, the officer post sightlines, logbooks for unannounced rounds, and camera locations. In each living unit, the Auditor entered at least two cells and was able to confirm that the viewing of the toilet in each cell from the small window in the door is limited to incidental viewing for security reasons; there were no privacy issues. The Auditor noted that the opposite gender announcements were made consistently. Throughout the tour the Auditor saw audit notices, PREA signage highlighting methods for reporting sexual abuse and assault, and information about zero tolerance. A detainee phonebook was located at each detainee phone containing PREA information about how to use the telephone for anonymous reporting. On the bulletin boards is information on how to contact consulates. Throughout the tour the Auditor also noted any issues that would need further review for PREA compliance later in the audit. The Auditor also spoke informally with 12 staff and 7 detainees regarding PREA issues during the tour. Everyone was very cooperative and informative in their responses. IAH has 108 security staff (50 male and 58 female), 24 medical staff, and 3 mental health staff, in addition to a variety of other positions (additional staff and one contractor), such as those who carry out essential facility functions such as religious services, volunteer organizations and oversight, recreation, maintenance, commissary, warehouse, laundry, and food service.

The detainees at IAH arrive at the facility through a sallyport entrance before being delivered to the intake area in the part of the building dedicated to the detainee living areas and support areas. The intake process at IAH is the first step for all detainees arriving at the facility. Although the Auditor viewed the intake areas and discussed the intake process with Intake Supervisor and the PSA Compliance Manager, the Auditor was unable to observe the intake process of a detainee since no new detainees arrived at the facility during the three days of the on-site audit.

On the first day of the audit, the PSA Compliance Manager gave the Auditor a detainee roster; he selected a sampling of 15 detainees for interviews on that day. At the time of the on-site audit the facility had no detainees identified as lesbian, gay, bi-sexual, transgender or intersex (LGBTI). IAH also had no mentally or physically disabled detainees (including vision or hearing impairments), no detainees who had filed a grievance related to sexual abuse, and no detainees who had been placed in segregated housing for risk of sexual victimization after a PREA allegation. Among the 15 detainees selected for interviews, 14 were limited English proficient (LEP) and 1 detainee spoke English. Of the 14 LEP detainees interviewed that day, 2 of them had also reported prior sexual abuse in their home countries. The Auditor began interviewing the 15 detainees immediately after the tour. He interviewed all of these detainees in a private office in the detainee housing area; all of the LEP detainees spoke Spanish or Portuguese, and the Auditor interviewed them by contacting Language Services Associates contracted through Creative Corrections LLC.

Of the 15 detainees interviewed on Tuesday, 3 LEP detainees reported that they had no problems with privacy issues and had never been pat-searched. They said they had seen the PREA posters and the orientation video but denied seeing any PREA information in the video they watched in the hold room; however, these three detainees later said they saw the same video in their living units and suddenly recalled seeing the PREA information. They also denied ever hearing any opposite gender announcements. Twelve other LEP detainees interviewed that day all said they had, in fact, received the handbook and other materials at intake in a language they could understand. They all also reported their understanding of PREA, including their right to report PREA violations anonymously and their right to have someone file a third-party report on their behalf. They reported having no privacy issues at IAH and all acknowledged hearing the opposite gender announcements. Those who had been pat searched said it was done in a respectful manner by a male officer. No one had been strip searched. All of the detainees said they did not fear for their safety at the facility.

On Wednesday, the Auditor interviewed 15 random detainees who were all LEP. They verified receiving their handbooks and seeing the PREA posters throughout the facility. They understood the protections PREA provides and reported they had no concerns for their safety. Those who were pat searched stated that the process was respectful and conducted by a male officer; no detainee reported being striped searched. The 30 detainees formally interviewed over the two days were from the following countries: Guatemala (1), Cuba (2), Venezuela (2), Nicaragua (15), Ecuador (2), Haiti (1), Brazil (4), Honduras (1), El Salvador (1), and Dominican Republic (1).

The interviews for staff took place in the office of the Training Manager/Investigator on Wednesday after the final detainee interviews. The Auditor began his staff interviews with the Training Manager/Investigator, followed by the personal interviews for 19 additional staff.

The 20 staff interviewed in person were:

- DW
- PSA Compliance Manager
- Director of Nursing (DON)
- Assistant Contracting Officer Representative, DHS/ICE
- Chief of Security
- Training Manager/Investigator
- Human Resource Assistant
- Deportation Officer (DO), DHS/ICE
- Mental Health Clinician
- Chaplain
- Intake Supervisor
- Two shift supervisors, one from each shift (supervisors work 12-hour shifts)
- Three detention officers, one from each shift (detention officers work eight-hour shifts)
- Registered Nurse (RN)
- Licensed Vocational Nurse
- Grievance Coordinator (GC)
- Food Service Manager

The interviews gave the Auditor a comprehensive view of the daily operations at IAH. The ACOR and the DO both made very positive comments about the professional working relationship between ICE and IAH; they said they had an open-door relationship with the administration at the facility and did not need to make an appointment to meet with the Warden. They were very complimentary about the facility's compliance with its various reporting duties, submitting policies for review and approval, and attention to various contract provisions. The Auditor noted the presence of upper-level management in all areas of the facility throughout the tour.

As there were zero allegations of sexual abuse reported at IAH for the prior 12-months period the audit period was extended to capture closed investigations that occurred since the facility's last audit. There had been two allegations of detainee-on-detainee sexual abuse since the previous audit, and the Auditor reviewed each of the files and interviewed the PSA Compliance Manager and the Assistant Contractor Officer Representative (ACOR) to learn about the process used at the facility when allegations occur. The PSA Compliance Manager prepares a brief synopsis for the ACOR

within two hours of any PREA allegation; the ACOR then refers the allegation to ERO for investigation. Of the two PREA allegation investigation files reviewed by the Auditor, one allegation was unsubstantiated and the other allegation was substantiated.

On Thursday, August 5, 2021, the ERAU Team Lead opened the exit briefing at approximately 4:30 P.M. After expressing her appreciation for the cooperation of all involved in the audit process, she turned the briefing over to the Auditor. The following attended the exit briefing:

- (b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU
- (b) (6), (b) (7)(C) Warden's Secretary, MTC
- (b) (6), (b) (7)(C) Administrative Sergeant
- PSA Compliance Manager, MTC
- DW, MTC
- COS, MTC
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
- ACOR, DHS/ICE
- DO, DHS/ICE
- Douglas K. Sproat, Certified DOJ/DHS PREA Auditor, Creative Corrections, LLC.

The Auditor also expressed his appreciation for the cooperation of everyone at IAH during the three days of the audit, highlighting in particular the helpfulness of the facility PSA Compliance Manager in organizing the interviews for detainees and staff. He further noted usefulness of the on-site portion of the audit had in providing him a better understanding of the operations at the facility. The Auditor stated that the 30 detainees interviewed, of which 29 were LEP's, all seemed to understand the protections PREA provides, and the staff interviewed were very knowledgeable about PREA and easily articulated how PREA benefits the detainees at IAH. The Auditor noted that the staff appeared to be very knowledgeable about PREA; they all attributed their knowledge to the frequency of the PREA training provided at IAH.

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: **4**
§115.31 Staff Training
§115.32 Other training
§115.51 Detainee reporting
§115.64 Responder duties

Number of Standards Met: **30**
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.42 Use of assessment information
§115.43 Protective custody
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 5
§115.41 Assessment for risk of victimization and abusiveness
§115.61 Staff reporting duties
§115.65 Coordinated response
§115.73 Reporting to detainees
§115.86 Sexual abuse incident reviews

Number of standards N/A: **2**
§115.14 Juvenile and Family Detainees
§115.18 Upgrades to facilities and technologies

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): MTC/IAH Policy 2.1.18, Protection from Harm, Prison Rape Elimination Act (PREA), October 13, 2020, sets out the zero-tolerance policy for IAH. It states, "The IAH Secure Adult Detention Facility through this policy establishes a mandatory zero tolerance position concerning all forms of sexual abuse and further outlines the facility's approach to preventing, detecting, and responding to such conduct should it occur. IAH is committed to a zero-tolerance standard for sexual violence, sexual misconduct, and sexual harassment between detainees and detainees and staff, volunteers, and contractors. This policy provides uniform guidelines and procedures to reduce the risk of prison sexual violence." The same policy requires the IAH Warden to appoint a PSA Compliance Manager to ensure that "all elements of this policy are met." Among the duties of the PSA Compliance Manager is the requirement to act "as the liaison with other agencies," and the PSA Compliance Manager told the Auditor that she is the point of contact with both ICE and with the Polk County Sheriff's Office, the local law enforcement agency with jurisdiction over IAH. The Auditor's review of the facility's organizational chart reflects that the PSA Compliance Manager reports directly to the Warden, and she confirmed to the Auditor that she has both the time and the authority to perform the duties of her job. Both the DO and ACOR said the facility's zero-tolerance policy had been approved by ICE. The DW, the COS, the PSA Compliance Manager, and the Training Manager/Investigator told the Auditor that the facility consistently emphasizes maintaining a zero-tolerance environment.

The Auditor conducted 30 formal detainee interviews at the facility; there were no detainees with disabilities such as being vision or hearing impaired at IAH during the audit. Of these 30 detainees who were interviewed, there was 1 who spoke English and 29 who were LEP. Of these 29 LEP detainees interviewed, 27 were random detainees and 2 were detainees who reported prior sexual abuse. Once the Auditor confirmed that all of them really seemed to understand PREA and the protections it provides, he inquired whether they felt that IAH was meeting its responsibilities for a zero-tolerance environment. All 30 detainees said they felt the facility was fulfilling its PREA duties to protect the detainees from sexual abuse.

The facility's policy meets the requirement of the standard, and the facility's practices are consistent with its policy.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b): MTC/IAH Policy 2.1.18 covers these subparts of the standard. Under this standard, a facility must ensure that its supervision practices are sufficient "to protect detainees against sexual abuse." Additionally, it must document the guidelines used to cover those supervision needs, with those guidelines being reviewed "at least annually." The facility's policy requires that the "Warden and the PREA Compliance Manager will assess the facility's operations whenever necessary to ensure that sufficient supervision of detainees are being met. This will occur once per year at a minimum to determine whether adjustments are needed to staff and monitoring as it relates to the prevention of sexual abuse or assault." IAH provided extensive documentation of its staffing practices, and the Auditor had ample opportunity to observe the facility's direct supervision practices and video monitoring practices during the on-site audit. Through his interviews, the Auditor learned that the Warden, the DW, the COS and the PSA Compliance Manager meet at least annually with an on-site representative from ICE to assess the adequacy of the facility's annual staffing plan. If there are any incidents that could be related to a staffing shortage, additional meetings to assess the plan will occur at that time. The Auditor reviewed the annual PREA staffing plan assessment and the staffing plan for the audit period; since there were no PREA allegations during that timeframe, there was no need for an adjustment to the plan for the following year. The annual review was completed on December 17, 2020. The Auditor also reviewed the facility's comprehensive detainee supervision guidelines about positions and staff deployment, post orders, staff ratios, and staff rosters for all shifts. All of the documents provided, showed that IAH carefully plans its staff deployment to maintain staffing ratios and schedules that provide sufficient staff for appropriate detainee supervision and monitoring.

(c) The Auditor interviewed the DW and the PSA Compliance Manager, two of the members of the PREA staffing plan review team, about the facility's practices for the annual review; the Warden, the third member of the review team, was not available for an interview. They told the Auditor the annual staffing plan review includes all elements of subpart (c) of the standard. The IAH policy requires that an evaluation of the need for direct supervision and video monitoring must include the following:

- "accepted detention and correctional facility practices.
- judicial findings of inadequacy.
- physical layout.
- composition of the detainee population.
- occurrences of substantiated and unsubstantiated incidents as it pertains to sexual abuse.
- length of detainee stay.
- any other relevant factors."

(d) MTC/IAH Policy 2.1.18 requires unannounced rounds by shift supervisors "to identify and deter sexual abuse of detainees." IAH requires these unannounced rounds to occur on all shifts, and staff must not alert other employees that these rounds are occurring unless "such announcement is related to the legitimate operational functions of the facility." These rounds must be documented as "PREA rounds." The detention officers interviewed by the Auditor acknowledged their awareness that such rounds were required on all shifts; they also said they knew they could not alert others about these rounds unless there was some kind of facility necessity. The Auditor reviewed the unit logs, and he verified through viewing the logs that shift supervisors were making these unannounced rounds on all three shifts. The unannounced rounds were documented and done according to IAH policy.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

This standard does not apply to IAH since the facility reports on its PAQ that it does not house juvenile detainees. Interviews with staff and detainees, along with on-site observations, confirm that the facility does not house juvenile detainees.

§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:

MTC/IAH Policy 2.1.18, along with facility practices, covers the requirements for this standard, although any references from subpart (e) of the standard to juveniles are not applicable since IAH does not house juveniles.

(b)(d)(e)(f): Cross-gender pat-searches and cross-gender strip searches and body cavity searches are limited to exigent circumstances by facility policy; such searches must be documented on a "Cross-Gender Pat Search Log" form or a "Body Cavity Search Log," both of which have a notice at the bottom of the form that the information must be submitted "to the PREA Manager and the Chief of Security before the end of shift." These search forms are kept in binders. The Auditor viewed blank copies of these forms. In their interviews, the security staff at IAH told the Auditor that only medical staff perform strip searches; the medical staff interviewed stated that they have not performed any strip searches during the audit period. All detainees are pat searched upon arrival, and all detainees reported to the Auditor that male officers searched them, with all searches being done in a respectful manner. All detainees interviewed denied ever being strip searched. A memo from the PSA Compliance Manager states, "IAH Secure Adult Detention Facility has had no occurrence of cross-gender pat searches/strip search, or visual or body cavity search during this audit cycle."

(g): IAH policy also directs that "staff enable detainees to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their buttocks or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks." The single occupancy cells contain toilets within the cells, and any viewing of a detainee changing clothes or performing bodily functions is through a window in the door and is therefore incidental. The detainees living in dorms, at IAH, have toilets with partitions and showers with privacy curtains. Through direct observation, while on the tour, and through viewing of the toilet and shower areas of certain living units from master control; the Auditor was able to confirm that IAH provided ample privacy for its detainees, except in situations requiring incidental viewing. No detainee interviewed by the Auditor had any complaints about privacy issues. Facility policy also requires opposite gender announcements when female staff enter the housing units. At IAH, female security staff slightly outnumber male staff, and the Auditor observed that the female officers consistently made the opposite gender announcements; the primary language of the detainees at the time of the audit was Spanish, and the opposite gender announcements are made in English and Spanish.

(i): MTC Policy 903.02 Ensuring Safe Prisons states, "The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status." The Auditor's interviews with the Intake Supervisor, two shift supervisors and three detention officers reflect that staff have been trained not to conduct any search of this type. The Auditor was able to confirm from these interviews that the facility's practices were in accord with this standard.

(j) The Auditor reviewed a February 2021 training bulletin covering searches at ICE detention facilities covering cross-gender, strip, and body cavity searches, and he reviewed six staff training certifications for training in "general, cross-gender, transgender, and intersex searches" completed by IAH staff since the last PREA audit. The Auditor also reviewed five training files for detention officers for initial and refresher PREA training, including search techniques for cross-gender pat down searches and searches for transgender and intersex detainees. The Auditor determined that the training was completed and in compliance. The Training Manager/Investigator said the annual training has been very important in helping staff understand and reinforce their responsibility to the detainee population under PREA. The officers told the Auditor the annual training covered a lot of material, such as skills and/or techniques, they had never had to use; therefore, they felt the training was especially valuable in helping them maintain their competency in these skills.

(c) Subpart (c) does not apply to IAH since it is an all-male facility.

(h) Subpart (h) does not apply to IAH since the facility is not a Family Residential Center.

§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): MTC/IAH Policy 2.1.18, covers these subparts of the standard. Under the facility's policy, detainees with a variety of disabilities, such as those who are blind or deaf or have other hearing or vision impairments, who have limited reading skills, or those with LEP, must be provided the full scope of PREA information in formats they can understand or through techniques they can understand. PREA information, such as the DHS-prescribed Sexual Assault Awareness Information pamphlet and PREA information in the facility's Detainee Handbook, is provided to detainees who have no disabilities and who speak English or Spanish (facility documents/materials are routinely provided in English and Spanish). This standard requires that LEP detainees and those with a variety of disabilities "have an equal opportunity to participate in or benefit from all aspects of the…facility's efforts to prevent, detect, and respond to sexual abuse." The policy requires that IAH must "provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities." Additionally, the facility must provide "interpretation or assistance…to any detainee who speaks another language in which written material has not been translated or who is illiterate." Much of the information for detainees, including but not limited to, intake/orientation materials, PREA information that is posted on housing unit bulletin boards and in an orientation video, is both English and Spanish. The orientation video covers all rules, regulations, and PREA responsibilities and requirements. In addition to the ICE National Detainee Handbook and an ICE Sexual Assault Awareness Information pamphlet distributed at intake in English or Spanish, the facility can print copies of the ICE National Detainee Handbook in Punjabi, Russian, Arabic, Chinese, French, Haitian Creole, Portuguese, Hindi, and Vietnamese, along with the ICE Sexual Assault Awareness Information pamphlet "Preventing Sexual Abuse and Misconduct" in Arabic, Haitian Creole, French, Hindi, Portuguese, Punjabi, and Chinese.

If the population at IAH includes detainees with hearing, vision, or speech impairments, detainees with limited reading skills, or detainees with intellectual or psychiatric disabilities, the facility must ensure the use of whatever technique or device will aid satisfactory communication with these

detainees about PREA and its benefits. IAH has a TTY telephone in the Law Library for the use of hearing- impaired detainees, and the orientation program is a video in English and Spanish. There are also signs at the facility advising the detainees of options for accessing information with sign language, and there are posters around the facility highlighting a language line for interpretation and translation purposes.

There were no hearing or vision impaired detainees in the population during the audit, nor were there any detainees with mental impairments or low reading levels. During the interviews with the Intake Supervisor, the PSA Compliance Manager, and the DON, the Auditor specifically inquired about the facility's methods for effectively communicating PREA-related information to detainees with various disabilities. The Intake Supervisor stated there have been low-vision and low-hearing detainees in the past, and staff have always found a way to communicate PREA information to them satisfactorily. For low-vision detainees, the orientation video, of course, has an audio component; and other materials can be read aloud by staff to English- or Spanish-speaking detainees. Should the low-vision detainee require some other language, the facility uses the interpretation service to convey the information. For detainees with hearing deficits, sign language services are available through Language Line Solutions. The facility also had a TTY device for detainees with hearing issues. There have been occasions where it was necessary to have PREA materials read to some illiterate or low-functioning detainees, sometimes requiring repeating passages or simplifying the language. The Intake Supervisor noted that a few years ago the facility had a deaf detainee, and IAH was prepared to accommodate this disability but the need for any special treatment did not arise since the detainee could read lips. Both the Intake Supervisor and the DON told the Auditor that any detainee arriving at IAH with an obvious mental impairment would immediately be referred to medical/mental health for a private evaluation of the detainee's cognitive ability. The facility requires that detainees sign a form verifying that they received/viewed the orientation materials, including PREA information. The Auditor viewed five detainee files the first day and five the second day; all ten files contained this form verifying an understanding of the materials, regardless of whether the detainee interviewed spoke English or was LEP and had been interviewed through the use of the language interpretation line.

The Auditor verified with the PSA Compliance Manager that IAH uses Language Line Solutions as its language line service. The PSA Compliance Manager told the Auditor that the interpretive service could also be used for any instances where written English materials needed to be translated into written materials in the language of the detainee. The Auditor observed that some detainee materials, including the ICE Sexual Assault Awareness Information pamphlet were in English and Spanish. IAH also has the ability to print this pamphlet in other languages provided by ICE. He also viewed portions of the orientation video to confirm that it was in English and Spanish. During his interviews with Intake Supervisor, the PSA Compliance Manager, and the DON, the Auditor specifically inquired about the facility's methods for effectively communicating PREA-related information to detainees who are LEP. They told the Auditor that facility staff use Language Line Solutions to communicate with those who do not speak English or Spanish. Staff use this line for interpretation or translation when needed and document that use in the detainee file. Detainees may also be brought to medical if there is some reason to believe that the language line needs to be used in a private setting.

The Auditor interviewed 29 LEP detainees through using Language Services Associates. All of these detainees stated through the interpreter that they had received information about the facility's policy to prevent, detect, and respond to sexual abuse in a language they understood. The Auditor also reviewed ten detainee files to confirm the facility's practice of documenting the language a detainee spoke, along with a written verification from the detainee that he understood the materials/information that IAH provided.

(c): If an LEP detainee needs to make a report about an instance of sexual abuse, the facility is required to address that situation so the detainee can effectively have his information communicated. IAH must make the facility's language services line available for interpretation or translation assistance as needed. Under the facility's policy, "At no time will staff rely on detainee interpreters, detainee readers or other types of detainee assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the detainee's safety, the preservation of evidence, or the investigation of the detainees allegations." Staff themselves are not to initiate a request for a detainee interpreter as a matter of convenience, since another part of the policy directs that "all staff be trained to understand that a detainee may act as an interpreter for another detainee, upon request, in reporting a SAAPI allegation. Training should include how and where this would be appropriate." Under the standard, "The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged the abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to sexual abuse." The staff interviewed by the Auditor said they understood detainee interpreters could be used at the request of a detainee, provided the usage of a detainee interpreter met the ICE guidelines for such use. The detainees told the Auditor they knew they could request another detainee to interpret for them, although none of the detainees said they had asked to use a detainee interpreter.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(c)(d)(e)(f): MTC/IAH Policy 2.1.18 covers almost every aspect of the requirements of this standard, and facility practice covers the portion omitted from the policy, along with expanding upon some parts of the policy. IAH requires a background check for every potential employee, contractor, or volunteer considered for work or for offering services requiring detainee contact. Under the policy, IAH does not hire or promote anyone who has contact with detainees "who has attempted to engage, engaged in or been convicted of any type of sexual activity; or who has been civilly or administratively adjudicated for engaging in or attempting to engage in sexual misconduct." The facility's application for employment, which can be completed online or in hardcopy form, addresses possible sexual misconduct by applicants in a more specific way than the statement in the policy. The application, which the Auditor reviewed, seeks detailed information of the type specifically cited in the standard. There are questions about whether a potential employee or contractor "has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution…." The application also covers issues such as whether the applicant "has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity." The HR assistant told the Auditor that not only were these PREA-related questions a part of the application itself, but the questions were also asked of the applicants during the interview process. The facility policy sets out that "material omissions regarding misconduct or false information will be grounds for termination or withdrawal of offer of employment." The discovery of whether someone has made such omissions or provided false information is partly a function of HR's efforts to "obtain any information on substantiated allegations of sexual abuse or resignation in lieu of pending investigation" and partly a function the required applicant background check, including a criminal records check, done in accord with and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive. This very thorough background check is to determine "suitability for employment" for working as an employee or contractor at IAH. MTC currently has a contract with Accurate to conduct these background checks; prior to July 2021 a company named IDS handled the background checks. IAH policy requires an "updated background check" every five years for those with detainee contact, and the HR assistant noted that updated background checks are also required for those seeking promotions.

Applicants for promotion, under both the policy and the standard, will also be asked "either in writing or verbally" the PREA-related questions previously listed. IAH, as stated in its policy, "reserves the right to forward any information to requesting employers…."

The portion of the standard not addressed in IAH policy is the requirement for the facility to "impose upon employees a continuing affirmative duty to disclose any such misconduct" of the type covered by the PREA-related questions asked during the hiring process. The HR assistant assured the Auditor that this on-going duty to disclose such information is a part of the facility personnel practice. During the post audit phase, the facility provided six copies of an employee's duty to disclose misconduct acknowledgement thus confirming compliance with subsection (b) of the standard

Though review of Executive Order 10450 Security Requirements for Government Employment, Office of Personal Management Section Part 731 Suitability, and ICE Directives 6-7.0 and 6-8.0, it was determined the agency has established a system of conducting criminal background checks for new employees, contractors, and volunteers who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement setting; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in such activity. Department of Homeland Security 6 Code of Federal Regulations Part 115 (Standards to Prevent, Detect, and Respond in Sexual Abuse and Assault Confinement Facilities) form contains a statement indicating that applicant responses are true and correct to the best of his/her knowledge. If the applicant knowingly and willfully gives a false response it may result in a negative finding regarding falsifying or omitting information, and he/she will be rejected from the selection process. The Assistant Deputy Division Director of the OPR Personnel Security Unit (PSU) informed Auditors who attended training in September 2018, that all ICE staff and any ICE contract employees must clear a background investigation through PSU before hiring or promoting any staff or contractor who may have contact with detainees. The contractor or staff complete an Electronic Questionnaire for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. The PSU Assistant Deputy Division Director explained the sexual misconduct questions are asked of the potential employee as part of the e-QIP. The candidate suitability for all employment 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. Applicants are questioned directly about any such previous misconduct both during their background check and during the job interview process and a positive response to any of those specific questions are grounds for unsuitability, including material omissions or making false or misleading statements in the application. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE. If it is a contract employee, the office informs the contractor the employee cannot perform work on behalf of ICE.

The Auditor examined personnel files for five medical staff, five food service staff, five volunteers, five detention officers, five security supervisors, and five administrative support staff. They all included the suitability screening information, as well as the application showing that the answers to all of the required PREA questions were satisfactory. The Auditor's file review also included checking to see whether five-year background checks were in the files for all staff, volunteers, and contractors who had been at IAH more than five years and updated background checks for staff who had been promoted. All of the background checks in the files were compliant with the standard.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): This standard is non-applicable as IAH has not acquired a new facility, made substantial expansion, or updated their video monitoring system during the audit period.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a): MTC/IAH Policy 2.1.18 covers the requirements for this standard. The facility has the responsibility for administrative investigations. It uses a "uniform evidence protocol" which was "developed in coordination with DHS…." The PSA Compliance Manager and the Training Manager/Investigator told the Auditor the facility follows a uniform evidence protocol. The facility sets out a variety of steps that staff and others must follow to assist with evidence collection and/or preservation to be used for administrative and criminal investigations. These steps include, but are not limited to, such things as the following:

- First responders must "[p]reserve and protect any crime scene until appropriate steps can be taken to collect any evidence…."
- First responders also must request that both the alleged victim and the alleged perpetrator not take any action that would "destroy physical evidence…."
- If the alleged victim is examined at the facility, "the extent of the injuries [and] all findings should be documented both photographically and in writing and placed in the detainee's medical record, with a copy to supervisory security staff and appropriate law enforcement officials."
- If deemed necessary by facility medical staff, IAH will send the alleged victim "to an outside medical facility for clinical examination, for assessing physical injuries and collecting any physical evidence of sexual assault."

The agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, 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 OIG, OPR, or the local law enforcement agency, the AFOD would assign an administrative investigation to be conducted.

(b)(d): The facility has the responsibility to "make available, to the full extent possible, outside victim services following incidents of sexual abuse; the facility shall attempt to make available to the victim a victim advocate from a rape crisis center." Upon the victim's request, the presence of a victim advocate must be allowed for support if there is a forensic exam or an investigatory interview. IAH has an MOU with Sexual Assault & Abuse Free Environment (SAAFE) House to provide such victim advocates for detainees. The Auditor reviewed the MOU and also saw information (English and Spanish) about SAAFE House posted in the living units. Detainees can call SAAFE House without cost through the use of telephones at the facility. The telephone number and mailing address for this community resource are in the facility's Detainee Handbook. The Auditor hoped to learn more about the

services provided by SAAFE House while he was on-site, but he was never able to speak with a representative of the organization in spite of repeated efforts by the PSA Compliance Manager to arrange a telephone call. The Auditor asked the PSA Compliance Manager to identify detainees for interviews who could come under the heading of targeted detainees; she then identified two detainees who had revealed at intake a history of sexual abuse in their home countries. When interviewing these detainees, the Auditor asked (through Language Services Associates) if they had been offered medical and mental health services when they reported this history of sexual abuse at intake; both detainees said such services had been offered. The Intake Supervisor told the Auditor that any detainee who reports a history of sexual abuse at intake is automatically referred for medical and mental health services. The mental health clinician reported to the Auditor that he addresses all such referrals immediately.

(c): By policy, when necessary, and at no cost to the detainee, the facility will make arrangements for a forensic examination. Such examinations are to be performed only by qualified practitioners, with the policy mentioning only a Sexual Assault Nurse Examiner (SANE) as a type of qualified practitioner. However, under the standard, other qualified health care personnel can do this type of examination if no Sexual Assault Forensic Examiner (SAFE) or SANE is available. Detainees are transported to St. Luke's Memorial Hospital in Livingston for forensic examinations. There were no forensic examinations performed during the audit period.

(e): Under IAH policy, "To the extent possible the Warden will request that outside investigative authorities conduct the investigation in accordance with PREA investigation standards." The DW, the PSA Compliance Manager, and the COS told the Auditor that the Warden had made such a request. In addition, the facility provided the Auditor with a copy of their updated MOU with the Polk County Sherriff's Office confirming compliance with sub section (e) of the standard.

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

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

Notes:

MTC/IAH Policy 2.1.18, supplemented by facility practice, covers the requirements for this standard.

(a)(b)(d): The first subpart of the standard is that "the agency [ICE]" must see that the facility has protocols in place "to ensure that each allegation of sexual abuse is investigated by the…facility or referred to an appropriate investigative authority." The facility's policy requires that "[a]n administrative or criminal investigation will be completed for all allegations of sexual abuse or sexual harassment." IAH has a duty to promptly report all allegations to ICE, and the facility notification begins with a report to the ACOR. Also, unless the act alleged is not potentially criminal, the facility has the responsibility to report the allegation "to an appropriate law enforcement agency with the legal authority to conduct criminal investigations." In the case of IAH, the notification to the FOD through the ACOR amounts to notifying the appropriate law enforcement agency since ERO is the primary investigating entity for IAH. However, the Polk County Sheriff's Office is also notified and can perform the investigation if the case is not accepted by ERO. The PSA Compliance Manager and the Training Manager/Investigator told the Auditor they ensure that an administrative or criminal investigation occurs for every allegation; they also confirmed their knowledge of the facility's duty to report allegations to the ACOR and to local law enforcement. The ACOR advised the Auditor that the ERO investigators are qualified to conduct the PREA investigations because of their specialized training in conducting investigations in a confinement setting. Facility policy requires IAH to keep all reports, documents, case records, and other materials related to allegations of sexual abuse "for a minimum of the time the detainee is housed at the facility plus 10 years." The facility also has a policy requiring "the documentation and maintenance, for at least five years, of all reports and referrals of allegations of sexual abuse."

RECOMMENDATION: Having two similar policies with different time periods for the retention of records is confusing. The facility should consider combining the two policies and deciding on a single retention period, so long as that period is at least five years to conform to the standard.

The agency's policy 11062.2 outlines the evidence and investigation protocols. All investigations are to be reported to the Joint Intake Center (JIC), who routes the case appropriately to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation, and the AFOD would assign an administrative investigation to be completed.

(c) Facility practice addresses this subpart of the standard. Based on the standard, IAH must "post its protocols on its website, if it has one, or otherwise make the [PREA investigatory] protocol available to the public." Finding the investigatory protocols on the MTC website is a challenge. If someone knows to search for "PREA," they can find a spread sheet that lists some related standards and specifies if MTC or some outside entity performs the function required by that standard. In the Auditor's view, that information hardly represents the intent of what is required. However, the PREA investigatory protocols are available for viewing if one decides to read the 2020 PREA Annual Report: mtctrains.com/wp-content/uploads/2021/06/2020-PREA-Annual-Report-Final.pdf. The protocols for ICE investigations are found on the ICE website, www.ICE.gov/prea.

RECOMMENDATION (c): Material that is to be made available to the public, such as a company's investigatory protocols as specified in the standard, should be easier for the general public to locate. It should not be hard for MTC to place a link to these protocols in some difficult-to-miss location on the company website.

(e)(f): Under the standard, when there are allegations of detainee-on-detainee abuse and both are residents of the facility, or when the allegations of detainee abuse involve "a staff member, contractor, or volunteer," the facility must make the following notifications: "Joint Intake Center (JIC), ICE OPR or DHS Office of Inspector General (OIG), as well as the appropriate Field Office Director…." Although the notifications required by the IAH policy in the case of detainee-on-detainee abuse do not include JIC, OPR, or OIG, the ACOR told the Auditor that IAH was prompt and careful to make all required notifications. The facility's notification list does include the FOD (through the AFOD) and the "appropriate law enforcement, when applicable." The policy lists the Polk County Sheriff's Office as a local law enforcement entity that may assume "control of a criminal investigation." The DW, the PSA Compliance Manager, and the Training Manager/Investigator acknowledged that the facility policy does not contain a comprehensive notification list for allegations; however, they told the Auditor that they all had knowledge of what offices had to be notified.

RECOMMENDATION (e)(f): The notifications required for various DHS/ICE entities under these subparts of the standard are numerous and are only addressed in an incomplete manner in facility policy. Although all notifications have apparently been successful, based on current facility practices, it is recommended that the specifics of the notifications be added to facility policy. Although IAH has had a very low incidence of allegations made over the last few years, that could certainly change. If the number of notifications does increase over time, incorporating the notifications in facility policy could be a benefit to anyone having make numerous notifications in a time of potential crisis.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c): MTC/IAH Policy 2.1.18 covers the requirements for this standard. All employees who have detainee contact are required to have extensive training on PREA-related topics, and the IAH policy specifies a large number of topics that include the nine topics included in the standard. Some of those topics include the facility's zero-tolerance policy, how to communicate professionally with detainees regardless of issues related to gender status/preference/orientation, methods for reporting knowledge or suspicion of sexual abuse, and the requirement to limit any information about sexual abuse situations to those with a need to know. All of this required training is essential for anyone working in an institution. All full and part-time employees go through the facility's initial new employee training, followed by refresher training annually. Training for staff, volunteers, and contractors will be based on the level of services provided in relation to contact with detainees. All completed training will be documented so that IAH can verify that those having contact with detainees have been trained. The Auditor reviewed a number of training files to verify initial and annual refresher training: files for five correctional officers, five administrative/support, five medical, five food service, and five security supervisors. The Auditor was able to verify that the staff received the training, both initial and the annual refresher training, as required by facility policy. Both the initial and the annual refresher training contain PREA components, and the Auditor reviewed the PREA component of the refresher annual training. He also viewed the training logs for this annual training. The Training Manager/Investigator and security supervisors stated the facility's emphasis on training provides staff with repeated and effective reminders about their responsibilities under PREA for the detainee population. The facility's PREA training, with the facility's requirement for annual refresher training, helps to reinforce the PREA-compliance efforts at IAH and clearly exceeds the standard.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c): MTC/IAH Policy 2.1.18 covers the requirements for this standard. By policy, IAH requires contractors and volunteers to be trained before they assume any duties. Contractors and volunteers are required to have the same initial and annual refresher training as staff members. Under IAH policy, the training about PREA is extensive, and it includes such information as learning about ICE/ERO and about the IAH "zero-tolerance policy and …how to report …incidents [of sexual abuse]." Through this training, they will learn "to fulfill their responsibilities under facility sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures." They are also trained to act as non-security first responders. The Auditor reviewed the PREA curriculum for annual refresher training, and he also reviewed the training files for five volunteers and one contractor. Through the Auditor's review of the files, he was able to confirm the training for these volunteers and one contractor. Covid-19 caused the suspension of the volunteer program at IAH so there were no volunteers available for an interview, and the single contractor was not on-site when the Auditor was at IAH. Although the facility policy refers to the amount of training being commensurate with the amount of detainee contact, in practice, all volunteers and contractors are required to attend the same annual training, regardless of the amount of contact they may theoretically have with detainees. The facility's contractor and volunteer PREA training requirement for annual refresher training helps to reinforce the PREA-compliance efforts at IAH and clearly exceeds 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)(e)(f): MTC/IAH Policy 2.1.18 covers all requirements for this standard. Although no intakes occurred while the Auditor was on-site, the interviews with intake staff, viewing the orientation video, and reading the materials distributed at intake provided ample verification that detainees are informed about the facility's zero-tolerance policies. The intake process covers all of the topics set out both in the standard and in the policy, such as definitions of sexual abuse, methods of self-protection, multiple ways to report sexual abuse, information about self-protection, right to receive treatment and counseling, and the right to be free from retaliation. The orientation video covers all rules, regulations, and PREA responsibilities and requirements. The Intake Supervisor advised the Auditor that detainees are always concerned that something they do will have a bad impact on their immigration status. She said that detainees learn during intake that making a report about sexual abuse will not have any negative impact on their immigration proceedings. IAH distributes a facility handbook in English and Spanish that contains PREA information, including information that will enable them to make reports of sexual abuse or seek support. The orientation video in English and Spanish is shown in the hold room during intake and during the week in the detainee living units Monday, Wednesday, and Friday at 9:30 AM. Much of the information for detainees, including but not limited to, intake/orientation materials, PREA information that is posted on housing unit bulletin boards and in an orientation video, is both English and Spanish. In addition, the ICE National Detainee Handbook and the ICE Sexual Assault Awareness Information pamphlet is distributed at intake in English or Spanish; the facility can also print copies of the ICE National Detainee Handbook in Punjabi, Russian, Arabic, Simplified Chinese, French, Haitian Creole, Portuguese, Hindi, and Vietnamese, along with the ICE Sexual Assault Awareness Information pamphlet in Arabic, Haitian Creole, French, Hindi, Portuguese, Punjabi, and Chinese.

(b): MTC/IAH Policy 2.1.18, covers this subpart of the standard. Under the facility's policy, detainees with a variety of disabilities, such as those who are blind or deaf or have other hearing or vision impairments, who have limited reading skills, or those with LEP, must be provided the full scope of PREA information in formats they can understand or through techniques they can understand. PREA information, such as the DHS-prescribed Sexual Assault Awareness Information pamphlet and PREA information in the facility Detainee Handbook and the ICE National Detainee Handbook, is provided to detainees who have no disabilities and who speak English or Spanish (facility documents/materials are routinely provided in English and Spanish). During intake, any detainees who are LEP (other than Spanish speakers, as noted above) or have some other disability--such as limitations with vision, hearing, reading, or comprehending--receive help as needed so they can understand the important PREA information provided at intake. The facility keeps the ICE National Detainee Handbook and the DHS-prescribed Sexual Assault Awareness Information pamphlet in English and Spanish, but the facility is authorized to print them in the other languages available through ICE. The policy requires the facility must provide "interpretation or assistance…to any detainee who speaks another language in which written material has not been translated or who is illiterate. If the population at IAH includes detainees with hearing, vision, or speech impairments, detainees with limited reading skills, or detainees with intellectual or psychiatric

disabilities, the facility must ensure the use of whatever technique or device will aid satisfactory communication with these detainees about PREA and its benefits. IAH has a TTY telephone in the Law Library for the use of hearing- impaired detainees, and the orientation program is a video in English and Spanish. There are also signs at the facility advising the detainees of options for accessing information with sign language, and there are posters around the facility highlighting a language line for interpretation and translation purposes. There were no hearing or vision impaired detainees in the population during the audit, nor were there any detainees with mental impairments or low reading levels. During the interviews with the Intake Supervisor, the PSA Compliance Manager, and the DON, the Auditor specifically inquired about the facility's methods for effectively communicating PREA-related information to detainees with various disabilities. The Intake Supervisor stated there have been low-vision and low-hearing detainees in the past, and staff have always found a way to communicate with them satisfactorily. For low-vision detainees, the orientation video, of course, has an audio component; and other materials can be read aloud by staff to English- or Spanish-speaking detainees. Should the low-vision detainee require some other language, the facility uses the interpretation service to convey the information. For detainees with hearing deficits, sign language services are available through Language Line Solutions. The facility also had a TTY device for detainees with hearing issues. There have been occasions where it was necessary to have PREA materials read to illiterate or low-functioning detainees, sometimes requiring repeating passages or simplifying the language. The Intake Supervisor noted that a few years ago the facility had a deaf detainee, and IAH was prepared to accommodate this disability but the need for any special treatment did not arise since the detainee could read lips. Both the Intake Supervisor and the DON told the Auditor that any detainee arriving at IAH with an obvious mental impairment would immediately be referred to medical/mental health for a private evaluation of the detainee's cognitive ability. In addition, an email provided by a Mental Health Practitioner employed by the facility stated, "Cognitively impaired detainees, during intake, would be routed to medical for evaluation to assess detainee's level of impairment by the mental health provider. Detainees with server impairment would be referred to the facility psychiatrist for treatment and/or medication management. It is the mental health provider that will ensure that cognitively impaired detainees understand the facility's zero-tolerance PREA education program.

(c): The facility requires that detainees sign a form verifying that they received and viewed the orientation materials, including PREA information. The Auditor reviewed ten detainee files and confirmed that IAH maintains the Intake Orientation Checklist, where each detainee has signed an acknowledgement of understanding the material provided to him during intake.

(d): Following the on-site visit, the facility provided the Auditor with photos that confirmed that the facility has posted signage that gives detainees information on where to make a report about sexual abuse. The photos further confirmed that the notices include the name of the PSA Compliance Manager and the names of national and state organizations providing help to victims of sexual abuse. Consulate information is also widely posted at the facility.

Of the 30 detainees the Auditor interviewed, all stated they received PREA information in a format they could understand during intake.

§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): MTC/IAH Policy 2.1.18 covers the requirements for this standard. It states, "In addition to the general training provided to all employees, specialized training is required for…investigations staff." This specialized training includes "techniques for interviewing sexual abuse victims, sexual abuse evidence collection in confinement settings and the criteria and evidence collection required to substantiate a case for administrative action or prosecution referral." The policy also sets out the requirement for maintaining documentation that investigators "have received specialized training." The PSA Compliance Manager, who was previously one of the facility investigators, told the Auditor that only qualified investigators are permitted to investigate sexual abuse allegations. The IAH Training Manager/Investigator showed the Auditor the training curriculum and signed training logs verifying her attendance at the specialized training for investigators. The Auditor also viewed her training certificate to verify her credentials as a qualified investigator. The IAH Training Manager/Investigator is currently the only investigator on staff who has completed the specialized training now required by IAH, which does contain all of the requirements of this standard.

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 Auditors reviewed the ICE OPR Investigation Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the ICE SharePoint to document compliance with the standard.

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

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

Notes:

(a): Does not apply since the are no DHS or ICE employees on the medical staff at IAH.

(b): MTC/IAH Policy 2.1.18 covers the requirements of this standard. The facility requires that "Medical and Mental Health Practitioners" at IAH are to receive specialized training that includes the following topics: "a) How to detect and assess signs of sexual abuse and sexual harassment; b) How to preserve physical evidence of sexual abuse; c) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and d) How and to whom to report allegations of sexual abuse and sexual harassment." However, any efforts by the healthcare professionals "to preserve physical evidence of sexual abuse" would exclude the performing of forensic exams; the DON told the Auditor such exams are performed elsewhere by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) at St. Luke's Memorial Hospital in Livingston, Texas. The Auditor reviewed the curriculum for the medical and mental health specialized training and determined that the curriculum covered the requirements of the policy and the standard. The Auditor reviewed four medical and one mental health staff training files; such review confirmed the initial and refresher PREA training and the specialized medical and mental health training for the staff.

(c): The PSA Compliance Manager and the Training Manager/Investigator both stated during their interviews that ICE has reviewed and approved the facility's policy regarding the specialized training of medical and mental health professionals working at IAH.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(f): MTC/IAH Policy 2.1.18 covers the requirements of this standard. Within 12 hours of arrival at IAH, "all detainees will undergo screening consistent with classification, health services, mental well-being, and unit policy." During this intake procedure, staff will screen detainees "to identify those who are likely to be sexual aggressors [to separate them] from those who are sexual abuse victims in order to prevent sexual abuse." To the extent possible, the facility must screen for nine items listed in the standard. Although these items are not listed in the IAH policy, they are all a part of the IAH Screening for Risk of Victimization and Abusiveness form reviewed by the Auditor: "(1) Whether the detainee has a mental, physical, or developmental disability; (2) The age of the detainee; (3) The physical build and appearance of the detainee; (4) Whether the detainee has previously been incarcerated or detained; (5) The nature of the detainee's criminal history; (6) Whether the detainee had any convictions for sex offenses against an adult or child; (7) Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the detainee has self-identified as having previously experienced sexual victimization; and (9) The detainee's own concerns about his or her physical safety." Facility policy prohibits disciplining a detainee who will not answer questions or who does not give a complete answer to certain questions. Detainees are separated from the general population during this screening process, and the facility considers whatever information it may have about prior acts and convictions for violence and/or sexual abuse in assessing sexual abusiveness. Housing, work, and program assignments use the information from the assessment and are in accord with the facility's efforts to prevent abuse or assault. The facility even considers the need to separate potential victims from potential aggressors when it has to assign transportation seating. When intake staff make medical referrals for follow-up, a health evaluation will occur within 2 working days, and a mental health referral results in an evaluation within 72 hours. The Auditor reviewed 10 detainee files to verify that the initial screening of detainees had been conducted within 12 hours of arrival; this review confirmed compliance with the 12-hour window for making the risk assessment. Any of the medical and mental health referrals in these files showed that follow-up evaluations occurred in a timely manner. Although there were no intakes when the Auditor was on-site, the interviews with the Intake Supervisor and the PSA Compliance Manager confirmed the practices of the facility as being consistent with the standard. The Intake Supervisor recounted one instance (not during the audit period) when 100 detainees arrived at the same time, and all detainees were processed in compliance with the policy; she explained to the Auditor that the facility is notified in advance of the number of detainees who will arrive, and there is an "all hands-on deck" approach to organizing sufficient qualified staff to handle the intake process when so many detainees arrive at once. The Auditor asked detainees about the intake procedures during their interviews. They all recalled the PREA-related questioning during the intake process.

(e): MTC/IAH Policy 2.1.18 states, "From the date of the initial assessment, unless an incident of abuse or victimization occurs or when warranted based upon other relevant information each detainee shall be reassessed for their risk of victimization or abusiveness between 60 and 90 days." Intake staff should conduct reassessments for victimization or abusiveness within 60-90 days after intake or whenever needed after an incident of abuse or victimization using the ICE Custody Classification Worksheet. The average stay at IAH is 26.35 days, and none of the 10 detainee files initially reviewed by the Auditor showed a reassessment. The Auditor was furnished with a completed reassessment from the current audit cycle done on the ICE Custody Classification Worksheet so that he could verify compliance with this section of the standard. Additionally, the Auditor reviewed Mental Health documentation for one of the detainee victims involved in and incident of sexual abuse, which was submitted post audit, and although the detainee was seen by mental health following the incident, the completion of a reassessment of the detainee could not be confirmed. In an email submitted to the Auditor, following the on-site audits, the facility stated, "post allegation reassessments were not conducted for the two detainee victims as they were released less than 90 days after the alleged incidents."

Does Not Meet (e): The facility was unable to provide documentation supporting a reassessment was conducted following an incident of abuse or victimization for the two detainee victims involved in the sexual abuse allegations. To become compliant the facility must provide, if available, a sample of sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse. In addition, the facility must provide confirmation that both the classification staff and investigators have received training regarding the requirement to complete the reassessment following an incident of sexual abuse or victimization.

(g) Because the intake process addresses a variety of sensitive issues, the facility limits how the information can be disseminated. Under the facility policy MTC/IAH 2.1.18, "All information given on any documentation shall remain private and confidential." The intake staff interviewed acknowledged their responsibility not to discuss information about a detainee gathered during intake. They all reported that once they entered the intake information into the computer, only certain staff had access to the data. The Intake Supervisor and PSA Compliance Manager confirmed that only certain staff could access the sensitive information compiled during intake.

§115.42 - Use of assessment information.

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

Notes:

(a): MTC/IAH Policy 2.1.18 covers the requirements of this standard. The policy states, "Intake staff will use the risk assessment form along with other supporting documents to determine how to assign detainee housing, the detainees ability to volunteer in the work program, and for recreation purposes along with other activities." The policy requires intake staff to use the information gathered at intake to make informed decisions about housing, recreation, work programs, and other activities. The use of this information allows for individualized decisions about what is best for safety of any given detainee. The Auditor reviewed five completed risk assessments (four provided on-site and one furnished on SharePoint) and determined that IAH took all of the information gathered during intake, including, but not limited to, the detainee's age and physical build, any disabilities, any history of victimization or abusiveness, his own concerns for his safety, and any identification as lesbian, bisexual, transgender, intersex, or gender non-conforming—to make careful judgments about placing each detainee in an environment where housing, work, and programs are safe for him. The Intake Supervisor and the PSA Compliance Manager said the intake information is used based on the standard and the facility policy in their classification of detainees.

(b): MTC/IAH Policy 2.1.18 requires "that housing and program assignments for transgender and/or intersex detainees are "considered on a case-by-case basis to ensure the detainees' health and safety." Decisions about a detainee's housing and program assignments must not be made "solely on the basis of identification of a transgender/intersex status unless such placement is for the purpose of protecting the detainee." Additionally, a detainee's personal view "with respect to their own safety will be given serious consideration." Medical or mental health professionals must be notified about the assessment "as soon as possible," and the housing and programs assignments for a transgender/intersex detainee must be reassessed at least twice a year. A memo from the Warden dated 6/10/21 stated, "IAH Secure Adult Detention Facility has not had a transgender/intersex reassessment in the year preceding the audit." The DON and the Intake Supervisor said the information about a detainee's identification as transgender or intersex is

known immediately upon assessment and is then factored into the process of housing and program assignments on a case-by-case basis. They told the Auditor that the detainee's own view of personal safety is also a part of making these assignments.

(c): MTC/IAH Policy 2.1.18 covers that where feasible, the facility gives transgender and intersex detainees the option to shower separately. The Auditor observed during the tour that the shower areas for the living units contained three or more shower stalls, all with privacy curtains that provided sufficient privacy for a detainee. The PSA Compliance Manager advised the Auditor that any transgender or intersex detainee who wanted to exercise the option to shower separately could notify staff at intake or could notify the officer in the living unit (either verbally or in writing) of the desire to shower separately. The detainee wanting to shower separately would then be scheduled to be the only detainee allowed to shower at that given time. This information would be documented in the logbook and in the detainee's file.

§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): MTC/IAH Policy 2.1.18, supplemented by facility practice, covers the standard. The facility has written procedures that address how to handle situations that may require protective custody/administrative segregation related to a PREA situation; according to the Auditor's interviews with the DO and the ACOR, all facility policies must pass through them and then on to the SDDO, the OIC, and the FOD for authorization. At IAH the norm is to avoid placing victims in protective custody/administrative segregation; according to the PSA Compliance Manager, who has been at IAH for several years and was the PSA Compliance Manager during the prior PREA audit, she told the Auditor she did not know of any circumstance where IAH was unable to find a less restrictive placement for a victim than placement in protective custody. Although there certainly have been no placements in protective custody/administrative segregation related to a PREA situation in recent years, both the PSA Compliance Manager and COS said if they had to make such a placement, the detainee would have access to all programs he would be able to access if in the general population.

(d)(e): Under the standard, the facility is to implement written procedures for the regular review of all vulnerable detainees placed in administrative segregation for their protection. The IAH policy directs that the FOD must be notified "as soon as possible" after any placement of a victim in administrative segregation for his protection based on a PREA situation. The placement in administrative segregation must be "the least restrictive housing," and the placement must not last longer than five days unless there are extenuating circumstances, or the detainee requests the extended placement. After the initial notification, the FOD is to review such placement to determine if the placement is a "last resort" and made only because "no other housing option[s] are available." Although there are timelines set out in the standard for notification to the FOD and for various reviews by supervisory staff, it appears that facility policy imposes timelines that speed up the process, such as notification to the FOD as soon as possible, which is to trigger a review at that point of the detainee's situation rather than the detainee having to wait possibly 72 hours for a review by facility staff. However, should the review by ICE, for whatever reason, not occur as contemplated by the IAH policy, the DW, the COS, and the PSA Compliance Manager were all knowledgeable about the provisions and timelines of the standard.

A June 10, 2021, memo from the Warden states, "IAH Secure Adult Detention Facility has not had an occurrence of a detainee placed in protective custody/administrative segregation due [to] high risk for sexual victimization or due to a determination being made that there was no available alternative means of separation from likely abusers, in the year preceding the audit." Both the PSA Compliance Manager and the COS told the Auditor there had been no detainees placed in protective custody due to a PREA incident during the audit period.

§115.51 - Detainee reporting.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b): MTC/IAH Policy 2.1.18, covers the requirements of the standard. The facility has policies in place to offer detainees multiple ways to privately report sexual abuse, retaliation, or staff neglect or violations of responsibilities that may have led to such incidents. Under the policy, detainees will be given information on reporting "sexual abuse or harassment to facility staff and/or private agencies not affiliated with IAH, and procedures for permitting third party reports of sexual abuse/harassment on [their] behalf…. All reports of sexual victimization, regardless of the source of the report and to whom the reports are given should be…documented and immediately reported. Detainees may privately report sexual abuse, sexual harassment, retaliation by other detainees or staff, and staff neglect or violation of responsibilities that may have contributed to such incidents." IAH policy provides that detainee reports can be made to staff members, through sick call, through third parties, by calls/written reports of DHS OIG or ICE/OPR, or through written requests or grievances "to the facility or ICE." The Auditor saw numerous notices in English and Spanish in the living units and visitation providing information about reporting, including anonymous reporting. Notices were posted with the names of consulates for countries around the world so that detainees could make reports; the notices also contained telephone numbers for reporting to various national and state organizations. The Auditor verified that both the local detainee handbook and the national detainee handbook contained reporting information. There are also notices at the facility telling detainees how to use "the PREA feature on Resident Phones." This feature allows the detainee to make a "confidential report" about sexual assault or harassment. The Auditor viewed English and Spanish posters in the living units and in visitation that provided contact numbers for third-party reporting of sexual abuse to the ICE Detention Reporting and Information Line (DRIL), the DHS Office of Inspector General (OIG), and the IAH PSA Compliance Manager. The Auditor tested a telephone in a living unit to call the DRIL and found the number to be functional. All detainees interviewed knew there were several ways to make a report, either for themselves or for another person, but all of the detainees denied ever making a report or helping anyone else to make a report.

(c): MTC/IAH Policy 2.1.18 states that staff must "accept reports made verbally, in writing, anonymously, and from third parties." The policy further dictates that "all reports of sexual victimization, regardless of the source of the report and to whom the reports are given should be…documented…" The Auditor asked every staff member interviewed if they had ever been approached by a detainee with a report or by a detainee who wanted help in making a report, but no staff member interviewed had ever accepted any verbal, written, or anonymous PREA report from a detainee or third party. These staff members also told the Auditor they had never been approached by a detainee for help in making a report.

The facility exceeds what is required by this standard because of the variety of ways it offers detainees for making a report.

§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): MTC/IAH Policy 2.1.18 and facility practices cover the requirements of the standard regarding the formal grievance process when there is a detainee grievance "related to sexual abuse or involve[s] an immediate threat to a detainee's health, safety or welfare…." Under this policy, such grievances can be filed without any restriction imposed on the time of filing, and these grievances "will be handled as time-sensitive…." The Auditor reviewed the detainee handbook and confirmed that it explains that a detainee can file a grievance related to sexual abuse at any time and that the detainee can receive help in filing the grievance from a variety of sources. During the tour, the Auditor observed various locked grievance boxes which only the Grievance Office could access; detainees have unimpeded access to grievance forms in the living units. All detainees the Auditor interviewed understood that they could file a grievance about sexual abuse, but they all denied having ever filed any grievance related to PREA.

(d)(e): The GC told the Auditor that whenever the facility receives a grievance related to sexual abuse, it has 5 days for issuing a decision; the facility then has 30 days to respond if the detainee appeals the decision on the grievance. When this process concludes, the GC then sends these grievances and the decisions made in response to them to the ACOR. These results then go to the SDDO and to the FOD. Although the steps just listed cover the requirements of the facility policy and are always fulfilled, the GC told the Auditor the facility practice in addressing a PREA-related grievance, whether it deals with a previously unreported or unresolved abuse situation or a situation that poses a current threat to a detainee's safety is immediate action, so that the process of addressing the grievance is expedited. The GC immediately forwards the grievance to the PSA Compliance Manager, the facility investigator, the Warden, and medical personnel, in addition to making notifications to ICE. Consequently, medical personnel are immediately apprised of any medical issues.

(f): Detainees "may obtain assistance from another detainee, staff, family or legal representation." If a detainee wants some kind of outside help in filing his grievance, he can go to the officer in the unit who passes along the request to the shift supervisor or the GC so that the detainee's request can be addressed in a reasonably expeditious manner.

A memo from the Warden dated June 10, 2021, stated there had been no sexual abuse grievances or appeals during the audit period. The GC stated during her interview that there had been no sexual abuse grievances or appeals during the entire audit period.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d): MTC/IAH Policy 2.1.18 covers these subparts of the standard. The policy states: "IAH maintains a memorandum of understanding with the …[SAAFE] House, a community service provider that will assist in providing detainees with emotional support related to sexual abuse which may be used at the detainee's request. Detainees will be informed that any outside resources used for this purpose will be monitored and forwarded to the authorities in accordance with mandatory reporting laws prior to access." The Auditor saw posters in the living units at IAH that provided information to the detainees about this resource; contact information for SAAFE House is also in the facility's Detainee Handbook. The Auditor also saw notices on the bulletin boards in the living units that cautioned the detainees that the telephone calls to outside resources would be monitored and reported to authorities in accord with any applicable reporting laws. Detainees can call SAAFE House without cost through the use of telephones at the facility. The Auditor viewed the MOU, and PSA Compliance Manager made three attempts to arrange for the Auditor to speak with someone from SAAFE House to verify its services, but he was never able to speak with anyone. The PSA Compliance Manager told the Auditor that she has referred detainees to SAAFE House for services, but she did not know if any detainee had used the services offered by this community resource.

§115.54 - Third-party reporting.

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

Notes:

MTC/IAH Policy 2.1.18 has established methods to receive third-party reports of sexual abuse and it makes information available to the public on how to report sexual abuse on behalf of a detainee. The Auditor viewed English and Spanish posters in the living units and in visitation that provided contact numbers for third-party reporting of sexual abuse to DRIL, OIG, and the IAH PSA Compliance Manager. The Auditor tested a telephone in a living unit to call DRIL and found the number to be functional.

§115.61 - Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): MTC/IAH Policy 2.1.18 sets out the requirements for this standard. The policy states: "All staff members…must immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment, retaliation against detainees or staff and any neglect or violation of responsibilities that may have occurred at IAH Adult Detention Facility." The standard requires that the facility provide a method for reporting outside the chain of command, and at IAH, "Such information may be reported privately to any supervisor, the PREA Coordinator, or directly to the Warden." MTC also offers its employees a unique process for reporting violations of staff, contractors, and volunteers in a private manner that may very likely encourage the reporting of information that might otherwise not be reported: "MTC has also provided an Ethics Hot-Line which is available for staff to anonymously report knowledge of sexual abuse or sexual harassment by staff, contractors, or volunteers." The DW, PSA Compliance Manager, and COS all voiced their awareness of the Ethics Hot-Line; the COS in particular remarked that the fact the line could be used anonymously increased the chance of information being reported. Several staff interviewed by the Auditor stated they knew they could make anonymous reports on the Ethics Hot-Line.

(c): Under IAH policy, "Any reported information from staff made verbally, in writing, anonymously, and from third parties will be promptly documented by the shift supervisor. Apart from reporting to the shift supervisor or other designated staff acting in their official capacity, staff will not reveal any information related to a sexual abuse report to anyone. The shift supervisor will then report all allegations to the PSA Compliance Manager, along with the Warden." Staff interviewed by the Auditor demonstrated their knowledge of the need to avoid revealing information about a potential sexual abuse situation to anyone except those with a specific need to know, such as those who are involved in treating or protecting the victim or those who may need the knowledge in order to make decisions related to security, management, or investigations.

(d): The Intake Supervisor specifically stated that ICE decides what detainees are sent to IAH, however, in an email received post on-site audit by the Auditor, the ERO POC confirmed that the facility does not accept juveniles, but they do accept vulnerable adults. An email provided post on-site audit by the faculty stated that they would report the allegation to the PCSD and the FOD thus confirming that the facility does not report the sexual abuse of a vulnerable adult to Texas Health and Human Services as is required by Texas law.

Does Not Meet (d): The facility does not have a process in place to report an allegation of sexual abuse of a vulnerable adult to Texas Health and Human Services as required by Texas law. To come into compliance with section (d) of the standard, the facility must document training of upper-level staff responsible for reporting PREA allegations to entities outside the facility in instances that require such reporting. In addition, should the facility encounter an incident of sexual abuse regarding a vulnerable adult, the facility must provide documentation that the report to Texas Health and Services as required by Texas law.

§115.62 - Protection duties.

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

Notes:

MTC/IAH Policy 2.1.18 addresses this standard. Under the policy, "staff are to take immediate action to protect detainees from sexual abuse and assault if they have reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse." Interviews with the PSA Compliance Manager, the Deputy Warden, and the Training Manager/Investigator confirmed that staff members are aware of their duty to act to protect a detainee if there is believable information that the detainee is facing the kind of risk described in the policy. Random staff questioned by the Auditor about their knowledge of the requirement to act if they reasonably thought a detainee was in "substantial risk of imminent sexual abuse" all knew what do in that kind of situation; they all said they had never been called to take action because of such "reasonable belief." All three of the IAH managers cited above told the Auditor that this directive for staff to act to protect the detainee is a part of the annual PREA training. The PSA Compliance Manager reported that there were no situations during the audit period where an employee had to act to protect a detainee against imminent sexual abuse.

§115.63 - Report to other confinement facilities.

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

Notes:

(a)(b)(c): MTC/IAH Policy 2.1.18 and facility practice together cover the requirements of the standard. A June 10, 2021, memo from the Warden states, "IAH Secure Adult Detention Facility has not had an occurrence of a notification of sexual abuse that occurred at another confinement facility within 72 hours to the agency or facility where the alleged abuse occurred. In the event this were to happen, the PREA Compliance Manager would call to notify the facility administrator." The PSA Compliance Manager told the Auditor during her interview that IAH received no notifications during the audit period regarding a detainee having been sexually abused in another facility; she also noted that the normal procedure when learning of an allegation about abuse at another facility is to make a telephone call to the proper entity to report the allegation. She would make the call within the time frame required by the standard, and an email about this telephone notification would serve as documentation of the notification.

(d): MTC/IAH Policy 2.1.18 does not contain a provision addressing the response of IAH should the facility receive a notice from another facility that a detainee alleges abuse while confined at IAH. However, the PSA Compliance Manager told the Auditor the allegation would be investigated by IAH like any other allegation. She advised that a report of the notification from the other facility would be made immediately to the ACOR; the PSA Compliance Manager also said the allegation is then reported up the ICE chain of command. The ACOR explained to the Auditor that reporting of the allegation up the chain of command means the notification from another facility about sexual abuse goes from him to the SDDO, to the OIC, and to the FOD.

RECOMMENDATION: Policy 2.1.18 should be supplemented to include subpart (d) of the standard, specifying the steps IAH would take whenever receiving a report from another facility that a detainee previously housed at IAH has made an allegation of having been sexually abused or sexually harassed while at IAH.

§115.64 - Responder duties.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b): MTC/IAH Policy 2.1.18 covers the requirements of this standard. At IAH, the first security staff and the first non-security staff member responding to a report of sexual abuse must perform essentially the same functions, beginning with separating "the alleged victim and abuser" and ending with calling "for additional medical and security staff." Whether security or non-security, the responder is to "[p]reserve and protect any crime scene until appropriate steps can be taken to collect any evidence…." Referring to "staff," the policy further requires that "if the abuse occurred within a time period that still allows for the collection of physical evidence," the staff member must then request both "the alleged victim" and the "alleged abuser" not to take any actions that could possibly destroy physical evidence, such as "washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating," while "security staff" must make the same request without the provision related to the abuse having "occurred within a time period that still allows for the collection of physical evidence…." During interviews with both security and non-security IAH staff, the Auditor found them all to be extremely knowledgeable carrying out their PREA responsibilities if they ever had to act as a first responder. Although they all carried a small PREA first responder book, not one of them had to refer to it when reciting their duties for the Auditor. They credited their annual PREA training for their familiarity with these duties. During the Auditor's interview with the Training Manager/Investigator, she provided five training files for each of the following categories: detention officers, volunteers, administrators/support, medical, and food service, to verify initial PREA training and annual PREA retraining. The Auditor also reviewed the training file of the single IAH contractor for this PREA initial and annual retraining. Everyone gets the same training on how to act as a first responder to PREA incidents. Even though the facility policy may refer only to "staff" and "security staff," volunteers and the single contractor—as noted—also participate in this first responder training.

In review of the two sexual abuse investigations that were conducted since the facility's last audit, no first responders were utilized. Since no one at IAH had to perform as a PREA first responder during the audit period, there were no documents to review regarding any actions by a first responder.

The required first responder training at IAH is the same for security and non-security staff, as well as volunteers and any contractor; it therefore exceeds the requirements of the standard.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): MTC/IAH Policy 2.1.18 has subparts that address two of the four requirements of this standard.

(a)(b): The standard requires a facility to have a written plan that outlines its plan for coordinating "actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership when responding to an incident of sexual abuse." The plan must cover the actions a multidisciplinary team would take to respond effectively when responding to sexual abuse allegations at IAH. There are directions in IAH policy for the first staff member responding to the scene, whether security or non-security, to separate the victim; that person is also responsible for making efforts to preserve the crime scene and calling for "additional medical and security staff." The policy directs that the "staff member who first identifies that an assault may have occurred should refer the matter to the shift supervisor, who will begin appropriate notifications and procedures in accordance with this policy." Facility medical and mental health must be notified immediately, and someone must "escort the victim to the Health Services unit." If medical staff determines that that the victim must be transported to "an outside medical facility," notifications must be made to the hospital, to security to arrange for transportation, possibly to a rape crisis center for the victim's support, and perhaps other entities. Law enforcement is to be notified, "when applicable."

(c)(d): When a detainee victim "is transferred to another facility, IAH will inform the receiving facility of the sexual abuse incident and the victim's need for medical or social services, unless the victim requests otherwise." The PSA Compliance Manager told the Auditor she would be the person making the notification to another facility if a detainee victim was being transferred. According to a June 10, 2021, memo from the Warden, "IAH Secure Adult Detention Facility has not had an occurrence of giving a notification to a receiving facility that a victim of sexual abuse was being transferred in the year preceding the audit." The PSA Compliance Manager supplemented this information by telling the Auditor that there had been no transfers of a detainee victim to another facility during the entirety of the audit period.

DOES NOT MEET(c)(d): The facility's policy regarding the transfer of a detainee victim and what information is to be provided to the receiving facility does not conform to the standard. The IAH policy does not make the distinction set out in the standard for "facilities covered by subpart A or B" and facilities that are not covered by these subparts. Subpart (c) of the standard requires the sending facility to send information about the detainee victim's possible need for either medical or "social services." The only restriction here is the possibility of a law that prohibits the transmission of such information without the victim's consent. There is no mention in the IAH policy of any legal restriction on passing along the required information to another immigration facility, i.e., one covered by subpart A or B. Subpart (d) of the standard allows the victim to decide what information to pass along; that is consistent with the wording of the IAH policy, except that the IAH policy does not set out that the victim's choice to decide what information is sent to the receiving facility is applicable specifically to non-immigration facilities. The facility needs to update the policy provisions reflecting the different requirements of subpart (c) and subpart (d) of the standard. The facility must provide training to the appropriate staff on the policy updates. The facility must provide the updated policy and the documented staff training for compliance review.

§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:

Although MTC/IAH Policy 2.1.18 states, "In the event that a detainee alleges sexual abuse of harassment by staff, contractors, or volunteers a no contact assignment will be imposed during the investigation." The DW, the COS, and the PSA Compliance Manager advised the Auditor that the facility practice is to immediately remove staff, contractors, or volunteers suspected of abuse from all detainee contact until an investigation is concluded. Of the two investigation files reviewed neither involved staff, contractors, or volunteers.

§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): MTC/IAH Policy 2.1.18 meets the requirement of this standard. One part of the policy states, "Detainees reporting or alleging a sexual assault will not be subject to retaliation," but another part sets out a broader scope for protection against retaliation by specifying that "any person" should be protected after an allegation, which is consistent with the requirement of the standard. It assigns the PSA Compliance Manager with the duty to "monitor for a minimum of 90 days following a report of sexual abuse any behaviors from any persons towards any person that may suggest possible retaliation and if behaviors are identified take prompt actions to remedy such behaviors." The policy spells out a variety of actions or behaviors to be monitored, all of which are consistent with the wording of the standard; the monitoring should include, but not be limited to, such things as "detainee disciplinary reports, detainee housing changes, detainee program changes [and] negative reviews or reassignments of staff." If retaliation is suspected, IAH must use "multiple protection measures…as necessary." Such measures, as spelled out both in facility policy and the standard, may include one or more of the following: "housing changes, transfers, removal of alleged staff or detainee abusers from contact with victims and emotional support services for staff and detainees." Under both the standard and the policy, monitoring is to continue for at least 90 days.

The PSA Compliance Manager advised the Auditor that she handles the retaliation monitoring at IAH. She provided a completed form showing the monitoring process arising from a PREA allegation in 2018. The facility's form is very detailed, listing various behaviors or actions the PSA Compliance Manager is to check for and a timetable for the process. The form also had plenty of space for comments. The form reflected the PSA Compliance Manager's timely initiation of the monitoring process, along with monitoring visits with the detainee that all occurred in advance of the visit dates listed on the form. Although the detainee was released before 90 days had passed after his allegation, the monitoring process was well documented for the period the PSA Compliance Manager monitored him, with no retaliation being noted. The Auditor also viewed the retaliation monitoring form arising for the only other PREA allegation since the last audit.

The Auditor's interviews with the Training Manager/Investigator, PSA Compliance Manager, and the DW confirmed the facility's protection against retaliation process.

§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): MTC/IAH Policy 2.1.18 covers this standard. Under its policy, if IAH must place a detainee victim in some type of administrative segregation for his protection, that placement must be the least restrictive housing option possible. The FOD must be notified "as soon as possible," and this placement cannot last "longer than five days, except in extenuating circumstances or at the request of the detainee." Additionally, a detainee victim in such placement cannot return to the general population until there is a reassessment and "no other possible threats or abuse are a factor." After the initial notification, the FOD is to review such placement to determine if the placement is a "last resort" and made only because "no other housing option[s] are available." Although there are timelines set out in the standard for notification to the FOD and for various reviews by supervisory staff, it appears that facility policy imposes timelines that speed up the process, such as notification to the FOD as soon as possible.
A memo from the Warden states, "IAH Secure Adult Detention Facility has not had an occurrence of a detainee victim of sexual abuse being reassessed before being returned to general [population] in the year preceding the audit." Since there were no allegations during the audit period, there were obviously no "post-allegation protective custody" placements made during the audit period. However, IAH provided the Auditor with a number of blank forms that would be used for a circumstance where such placement might be necessary: an administrative segregation order, special housing unit review form, administrative segregation review form, and a pre-segregation evaluation medical clearance. Most of these forms are tools used for the proper tracking and notification of various entities when a detainee requires post-allegation protective custody. The Auditor's interviews with the DW, COS, and the PSA Compliance Manager confirm this practice.

§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): MTC/IAH Policy 2.1.18 sets out most of the requirements of the standard, and facility practices address some parts of the standard not covered in policy; the policy is supplemented with this blanket statement: "All reports of alleged sexual abuse or assault must be handled and investigated in accordance with the Prison Rape Elimination Act (PREA)." The PSA Compliance Manager, who previously was a facility investigator with the responsibility for submitting an initial synopsis of the allegation to the ACOR within two hours of learning of an incident, said the investigations are done promptly, thoroughly, and objectively. The current facility investigator (i.e., the Training Manager/Investigator) stated that even though she has not yet conducted any investigation, she thoroughly understands the process of investigating an allegation, beginning with the immediate reporting of the incident to ICE, followed by an investigation that is prompt, thorough, and objective.

Under the policy, "An administrative or criminal investigation will be completed for all allegations of sexual abuse or sexual harassment." IAH conducts only administrative investigations, and the PSA Compliance Manager said an administrative investigation is mandatory after a criminal investigation is substantiated. She also told the Auditor that whenever a criminal investigation results in a finding of unsubstantiated, she first reviews the file of the investigation and then consults with ICE and/or the Polk County Sheriff's Office regarding the feasibility of an administrative investigation. Any final decision on IAH conducting an administrative investigation—whether the criminal investigation might have been done by ICE or the Polk County Sheriff's Office—must be made in consultation with ICE. Both the DO and the ACOR told the Auditor they would consult with IAH regarding any administrative investigation.

The Training Manager/Investigator and the PSA Compliance Manager stated that only specially trained investigators are authorized to conduct such investigations. The Training Manager/Investigator has completed specialized training and the Auditor viewed her certificate for verification. The current PSA Compliance Manager and one other staff member (no longer working at IAH) were the trained investigators in 2018 when the facility's most recent allegations occurred. Although either the Polk County Sheriff's Office or ICE may be the investigating entity for potentially criminal cases from IAH, ERO investigated the 2018 allegations, both of which were unsubstantiated. IAH consulted with ICE regarding the need for an administrative investigation for these allegations. The facility's policy and procedures relating to criminal and administrative investigations were approved by ICE. This information was provided to the Auditor through his interviews with the DO and the ACOR.

RECOMMENDATION: IAH should supplement its policy to include all provisions of subparts (a) and (b) of this standard so that the policy will reflect both the wording of the standard and the facility's actual practice.

(c)(d): Subpart (c)(1) of the standard has seven requirements that must be addressed in written procedures. The facility policy covers six of these subparts. Although the wording of the facility policy does not use the language of the standard to address these six subparts, it adequately spells out the requirements for everything except (c)(1)(iii), wherein the standard directs that an administrative investigation must include a review of "prior complaints and reports of sexual abuse involving the suspected perpetrator…." Following (c)(1)(vii) of the standard, the "reports of administrative and criminal investigations will be maintained for as long as the alleged abuser is incarcerated or employed by MTC, plus an additional five years." Subpart (c)(2) of the standard, which focuses on the sequence of the criminal and administrative investigations, is not explicitly part of the policy; however, the sequencing concept of criminal investigations before administrative ones is definitely part of facility practice, as confirmed by the PSA Compliance Manager, DO, and the ACOR. IAH is in substantial compliance with this subpart of the standard.

RECOMMENDATION: The facility should supplement its policy by adding the language of (c)(1)(iii) from the standard to the IAH directives for administrative investigations and adding language to its policy that follows the language of the standard that the facility's procedures "shall govern the coordination and sequencing of the two types of investigations."

(e): The facility policy states that "the departure of an alleged abuser or victim from the employment or control of IAH does not provide basis for terminating an investigation." The DW and the PSA Compliance Manager interviews confirmed the policy to be consistent with the standard, and that an investigation would not cease just because an employee or a detainee was no longer at IAH.

(f): The facility's practice, as related to the Auditor by the PSA Compliance Manager, is to extend on-going cooperation with any outside agency that may be investigating sexual abuse allegations at IAH. The policy imposes a duty to try "to remain informed about the progress of the investigation." ERO is primarily the "outside agency" handling the facility's PREA investigations, as evidenced by the spreadsheet provided for the two allegations arising in 2018. However, the policy also refers to the possibility that the Polk County Sheriff's Office may "assume control of a criminal investigation." The DO and the ACOR, who are both on-site at IAH, advised the Auditor that there are weekly meetings with the facility administration to cover or follow-up on any operational issues, to include PREA allegations and the progress of any investigations (whether criminal or administrative).

Since there were no allegations resulting in either a criminal or administrative investigation into a PREA allegation during the audit period, there were no recent documents to review. However, the Auditor did review the files for the only two allegations since the last audit; those allegations were reported in 2018. The investigative protocols were followed in 2018.

§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:

MTC/IAH Policy 2.1.18 does not have a provision that sets out the specific requirement of this standard. However, a standard about investigations following PREA requirements, a training standard pertaining to specialized training for investigators, and the substance of agency training combine to establish that the practice at IAH is to follow this standard and impose "no standard higher than a preponderance of the evidence" for administrative investigations into PREA allegations. Under the IAH policy heading "Investigation," there is a statement requiring "reports of alleged sexual abuse or assault must be handled and investigated in accordance with the Prison Rape Elimination Act (PREA)." In another part of IAH policy that addresses special training for investigators, it sets out that the curriculum must include "the criteria and evidence required to substantiate a case for administrative action or prosecution referral." The Auditor interviewed the Facility Training Manager/Investigator and the PSA Compliance Manager regarding the standard of evidence used for administrative investigations. They told the Auditor that the MTC specialized investigator training emphasizes that no standard higher than a preponderance of the evidence can be used to determine whether an allegation has been substantiated.

RECOMMENDATION: The facility should add a provision to its policy that clearly follows the language and intent of the standard that "no standard higher than a preponderance of the evidence" can be used to determine whether allegations can be substantiated.

§115.73 - Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

MTC/IAH Policy 2.1.18 has provisions consistent with the requirement of this standard. After the completion of an investigation into an allegation of sexual abuse, the facility must notify the detainee whether the outcome of the investigation is considered substantiated, unsubstantiated, or unfounded. The wording of the standard says the notification is to take place if the "detainee is still in immigration detention, or where otherwise feasible…." The policy addresses the possible problem of notifying an IAH detainee who is no longer in ICE custody in this manner: "if the investigation was conducted by an outside investigative authority, IAH staff will request relevant information from such authority in order to inform the detainee." The PSA Compliance Manager explained to the Auditor that she has the responsibility of notifying the detainee of the results of an investigation if the detainee is still at IAH when the investigation concludes. If the detainee is no longer at the facility and she has a forwarding address, she forwards the notification to that address. If there is no forwarding address at IAH, she requests the address from ICE and then forwards the notification. A memo dated June 10, 2021, from the Warden states, "IAH Secure Adult Detention Facility has had no occurrence of notifying a detainee who alleged sexual abuse results of an investigation in the last 12 months." The facility provided the Auditor with a blank form for detainee notification of investigation results; the Auditor reviewed the investigative files of the two sexual abuse allegations that occurred since the last audit. Neither file contained documentation that confirmed the detainee received notification as the results of the investigation. In an email provided to the Auditor, following the on-site audit, the ERO POC indicated he could not verify that the detainees were served the actual notices.

Does Not Meet: Neither the facility nor agency, could document that the two detainees involved in the reviewed investigative files were notified of the outcome of their sexual abuse allegation. To become compliant, the agency must notify a detainee as to the result of the investigation and any responsive action taken. Compliance must be demonstrated by submitting documentation that detainees at IAH are notified as required by the standard.

§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): MTC/IAH Policy 2.1.18 addresses the requirements for these subparts of the standard. Under the policy, any staff member who violates any of the facility's "sexual abuse and sexual harassment policies" is "subject to disciplinary sanctions," and "termination is the presumptive disciplinary sanction for staff…who have engaged in sexual abuse." The standard requires that ICE approve the IAH policy regarding discipline and adverse actions against staff for violating sexual abuse policies; through his interviews with the DO and the ACOR, the Auditor confirmed that these policies have been approved by ICE.

(c)(d): The facility's policy further provides that "terminations for violations of IAH sexual abuse and sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, will be reported to law enforcement agencies and any relevant licensing bodies, unless the activity was clearly not criminal." Staff interviewed by the Auditor told him they understood they could be disciplined, to include termination, if they violated the IAH PREA policies. The Training Manager/Investigator said that the topic of sanctions for staff because of PREA violations is strongly emphasized during training.

A memo dated June 21, 2021, from the Warden stated that IAH did not have any instances requiring "disciplinary or adverse actions" for staff violating the facility's sexual abuse policies. The facility provided copies of the following blank forms evidencing the facility's various types of disciplinary or adverse actions for staff violations of these policies: A Notice of Caution, a notice of administrative suspension, and a notice and letter of termination. The Auditor spoke with both the DW and the HR assistant about staff discipline imposed for PREA issues, and they both confirmed that there had been no such issues during the audit period, but procedures were in place and would be followed should such a circumstance arise.

§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): MTC/IAH Policy 2.1.18 addresses portions of this policy, while facility practices cover the subparts of the standard that are not addressed in policy.

(a)(b): The policy does not contain precise wording that prohibits the contact of contractors and volunteers who have engaged in or are suspected of sexual abuse with detainees during the pendency of an investigation, although it does provide that upon a detainee's reported allegation of "sexual abuse or harassment by staff, contractors, or volunteers [,] a no contact assignment will be imposed during the investigation." Another part of the policy says undefined "detainee abusers" can be removed from contact with victims if a detainee fears retaliation. However, based on information from the interview with the PSA Compliance Manager, the Auditor learned the facility does prohibit contractors and volunteers who have either engaged in sexual abuse or who are suspected of sexual abuse from further contact with detainees during the pendency of any investigation. Such separation does not depend on a detainee himself making an allegation of abuse or harassment or upon a detainee expressing a fear of retaliation. Since there have been no PREA allegations involving contractors or volunteers since the previous audit, there were no documents to review concerning the removal of any actual or suspected volunteers or contractors from contact with detainees.

Under a heading referencing disciplinary sanctions "for staff, contractors, and volunteers who have engaged in sexual abuse," the policy states the parameters of when it is appropriate to notify law enforcement bodies and licensing bodies of PREA violations or infractions. The PAQ notes that the facility does notify, as appropriate, law enforcement agencies and licensing bodies of PREA infractions by contractors and volunteers, and the Auditor's interview with the PSA Compliance Manager verified that the facility does make such notifications to law enforcement and appropriate licensing bodies for staff, contractors, and volunteers.

RECOMMENDATION: The wording of the current policy requires a report from a detainee to trigger a "no contact assignment…during the investigation." There is no requirement in the standard for a detainee to make an allegation about abuse or harassment from a contractor or volunteer or for the detainee to fear retaliation from a "detainee abuser" in order to trigger separation from a potential contactor or volunteer abuser. The facility should add a provision to its policy reflecting the wording of the standard so that the policy clearly states that contractors and volunteers who have engaged in sexual abuse or are suspected of sexual abuse are prohibited from contact with detainees while awaiting the conclusion of an investigation.

(c) In situations other than a contractor or volunteer actually "engaging in sexual abuse, "if there are "other violations of IAH sexual abuse and sexual harassment by staff, contractor[s] or volunteer[s], appropriate remedial measures and consideration will be taken to determine whether or not to prohibit further contact with detainees."

A memo from the Warden with a subject heading of "115.77 Corrective Action for Contractors and Volunteers," states that "IAH Secure Adult Detention Facility has had no occurrence regarding disciplinary or adverse actions for staff for violating the agency's sexual abuse policies in the preceding audit year." Presumably the phrasing of the memo inadvertently omits a reference to contractor and volunteers since the absence of PREA violations by contractors and volunteers was confirmed by the PSA Compliance Manager. The HR assistant's remarks during her interview with the Auditor also verified that there have been no sexual abuse policy violations by contractors or volunteers during the audit period. Therefore, there were no records for the Auditor to review.

§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)(d)(e)(f): MTC/IAH Policy 2.1.18 states, "when there is an administrative or criminal finding that a detainee engaged in detainee-on-detainee sexual abuse, formal disciplinary procedures will follow. Any sanctions imposed should "be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories. Another issue that must be considered when deciding to impose a sanction or determining the nature of a sanction is whether a detainee judged to be competent had any "mental disabilities or mental illness" that contributed to the detainee's actions. A detainee must not be disciplined for "sexual contact with staff" unless there is a determination that staff did not consent to the contact." Any reports of "sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred" will not be considered as making a false report or lying."

(c): In review of the two sexual abuse investigations that were conducted since the facility's last audit, one investigation included a disciplinary report for the alleged perpetrator charging him with "engaging in sexual acts." The documentation provided confirmed that the detainee disciplinary system included progressive levels of reviews, appeals, procedures, and that the process is documented.

§115.81 - Medical and mental health assessment; 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): MTC/IAH Policy 2.1.18 is consistent with the standard. Under the heading of "Screening, Classification, and Housing," IAH policy states, "Any detainee who alleges that they have been victims of sexual assault, prior history of victimization or history of prior sexual abuse while incarcerated will be referred to mental health. A detainee will receive a follow-up from mental health staff within 72 hours after a referral is initiated and medical staff will have no later than two working days from the date of assessment." The screening and classification process at IAH is described in the notes to §115.41; it uses an appropriate screening tool for seeking information about a detainee's history of victimization or abusiveness. If intake staff conclude that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff will, as appropriate, refer the detainee to a qualified medical or mental health practitioner. As outlined in the policy, medical referrals are addressed within two working days. If the referral is for mental health follow-up, the timeframe for an evaluation is not to exceed 72 hours. Although there were no intakes when the Auditor was on-site, interviews with the Intake Supervisor, the DON, and the mental health clinician confirmed the practices of the facility are consistent with the policy.

The DON stated that all referrals from intake for either medical or mental health evaluations can be handled in a timely manner in-house unless the services of a specialist are required. In those cases, the evaluations would have to take place off-site. She also stated that any referrals from the facility intake process that are of an emergency nature—whether related to sexual abuse or otherwise—would be matters of great priority and would be addressed immediately. She also verified that there were no referrals for medical evaluations from intake during the audit period.

The Auditor interviewed the mental health clinician, who said he tries to handle all referrals immediately, whether they come following intake or arise through sick call or some other way. The Auditor reviewed two detainee files showing PREA-related mental health referrals during the audit period arising from the facility's §115.41-type intake assessment. The Auditor reviewed another mental health referral evaluation/treatment file provided through SharePoint. All files reflected that the clinician's evaluation took place within 72 hours after the referral. All files contained notations verifying the use of the facility's language line whenever necessary for the practitioner to satisfactorily communicate with a detainee.

§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): MTC/IAH Policy 2.1.18 covers all parts of the standard. Under the facility policy, detainee victims of sexual assault have "timely, unimpeded access to emergency medical treatment, [and] crisis intervention services and all medical services will be provided to the victim without financial cost, regardless of whether the victim names the abusers or cooperates with the investigation." If determined to be necessary, detainee victims will be provided such services as treatment plans, referrals for continued care, and/or tests for STD's and HIV. All of these medical and mental health services "will be consistent with the community level of care." The DON and an RN told the Auditor that medical and mental health staff are aware of the services required by this policy, and they have never failed to respond appropriately. A memo dated June 10, 2021, from the Warden states, "IAH Secure Adult Detention Facility has had no occurrence regarding emergency medical/mental health services provided to a victim of sexual abuse in the preceding audit year." The DON told the Auditor there had been no situations during the audit period requiring emergency medical or mental health services. There were no files from the audit period to review.

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

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

Notes:

(a)(b)(c)(e)(f): MTC/IAH Policy 2.1.18 covers all parts of the standard. The policy states, "As deemed appropriate, victims of sexual abuse while detained IAH will be offered medical and mental health evaluations…." The medical department makes referrals and/or schedules appointments as needed, to include off-site referrals for specialized services for victims of sexual assault or abuse. Proper assessment and treatment of these victims may include any of the following: "a) Follow-up services, b) Treatment plans, c) Referrals for continued care following transfer or placement in another facility or release, d) Pregnancy test, e) Test for STD and HIV." During her interview, the DON stated that these services were not required during the audit period, but the medical/mental health department would follow the policy whenever the situation requires it. Under both the standard and the policy, any medical or mental health services for these victims is without cost to the victim and is without a requirement for naming an abuser or cooperating with an investigation. Additionally, any treatment must be "consistent with the community level of care." The DON told the Auditor that detainees receive medical and mental health services on-site, without charge. She also noted that all of these services would meet the community level of care requirement. The Intake Supervisor and the DON advised that the medical department at IAH does its own intake after a detainee goes through the facility's intake process. The DON also told the Auditor that there was no need for any off-site referrals during the audit period.

(d): This subpart is not applicable since IAH is a male-only facility.

(g): The facility policy, like the standard, recites that there will be an "attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." The mental health clinician told the Auditor he has never had to conduct a mental health evaluation of a detainee-on-detainee abuser. He further stated that if a detainee with such a history did come through intake with a resulting referral for an evaluation, he would attempt to conduct such evaluation immediately. A memo dated June 10, 2021, from the Warden stated, "IAH Secure Adult Detention Facility has had no occurrence regarding conducting a mental health evaluation of a detainee-on-detainee abuser within 60 days, in the preceding audit year." Consequently, there were no mental health evaluations of detainee-on-detainee abusers to review, but the facility did provide blank referral forms for review.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): MTC/IAH Policy 2.1.18 covers most, but not all, of the requirements for this standard.

Under IAH policy, the PSA Compliance Manager and the Warden "conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation to assess and improve prevention and response efforts. Such review shall ordinarily occur within 30 days of the conclusion of the investigation." Although the standard requires a written report only for substantiated or unsubstantiated allegations, facility policy appears to require a report for each incident review "to assess and improve prevention and response efforts." Those conducting the review must look at certain factors listed in both the standard and the policy: "race, ethnicity, gender identity, lesbian, gay, bisexual, transgender or intersex identification, status or perceived status, or gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility." After considering those factors, along with others listed in the policy, the reviewers should then be able to properly evaluate "whether the allegation or investigation indicate a need to change policy or practice to better prevent, detect, or respond to sexual abuse." If the reviewers do make recommendations for change, the facility "shall implement the recommendation for improvement or shall document its reasons for not doing so." The policy requires the PSA Compliance Manager to make an annual review of each year's data and any corrective actions so that the agency's attempts in "preventing, detecting, and response to sexual abuse" can be evaluated. While the language of the policy closely tracks most of the standard, the standard's timeframe for the completion of the report is 30 days; the language of the policy—that the review "shall ordinarily occur within 30 days of the investigation"—is structured more like a suggestion than a requirement. The Auditor reviewed a copy of the facility's PREA Annual Review Committee's Report dated 12/17/2020 and confirmed the facility is in compliance with section (c) of the standard.

In review of the two sexual abuse investigations that were conducted since the facility's last audit, the incident reviews included in the investigative files reflected that the reviewers considered the factors required as listed above, such as race, ethnicity, gender identity, etc. Each report indicated that there were no findings that would lead to any recommendations about changes needed in policies and practices. However, the reports do not establish whether the reviews occurred "within 30 days of the conclusion of the investigation," which is the requirement of the standard.

DOES NOT MEET (a): One incident review supposedly was done approximately two months before the date the investigation was closed, and the other incident review is not dated, so there is no way to determine whether it was done in a timely manner. These discrepancies or omissions may represent merely inadvertent oversights or typographical errors, but without correct dates for the end of an investigation and the date of the incident review, the Auditor is unable to determine if the facility has met the requirement for this standard. A reasonable way to address the problem would merely be to slightly revise the incident review forms to require the inclusion of the two dates. The facility needs to ensure that every incident review completed contains the date the investigation was completed, as well as the date the incident review was conducted. The facility needs to develop a process to ensure incident reviews are conducted within 30 days and training with the appropriate staff needs to be completed on the process. The facility must provide the developed process and the documented staff training for compliance review.

RECOMMENDATION: The policy language addressing the time period between the conclusion of the investigation and the preparation of the incident review report should reflect the timing of "30 days" as set out in the standard.

§115.87 - Data collection.

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

Notes:

MTC/IAH Policy 2.1.18 covers the requirements of this standard. It states, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case dispositions, medical and counseling evaluation findings and recommendations for post-release treatment and/or counseling, shall be maintained in a secure area. All documentation will be kept for a minimum of the time the detainee is housed at the facility plus 10 years." The PSA Compliance Manager confirmed this practice. The PSA Compliance Manager told the Auditor that the files are kept in a locked file cabinet in her office and that the office is locked when unoccupied. The Auditor observed the location of the files, and the security of these files satisfies the standard.

§115.201 - Scope of audits.

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

Notes:

(d): The Auditor was able to tour IAH without restrictions.

(e): The Auditor was able to revisit various areas as needed, and facility staff promptly provided any documentation requested for the Auditor's comprehensive review of the facility's PREA practices.

(i): The Auditor was able to conduct private interviews with detainees and staff.

(j): The audit notice in English and Spanish was posted in all living units, but the Auditor did not receive any correspondence from either detainees or staff.

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:	4
Number of standards met:	30
Number of standards not met:	5
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.

Douglas K. Sproat, Jr. 9/5/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 10/20/2021

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 10/21/2021

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Douglas K. Sproat, Jr.	**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:**	772-579-(b) (6), (b)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Houston Field Office
Field Office Director:	Daniel Bible
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	126 Northpoint Drive
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	IAH Secure Adult Detention Facility		
Physical address:	3400 FM 350 South, Livingston, Texas 77351		
Mailing address: *(if different from above)*			
Telephone number:	936-967-8000		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	936-967-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	936-967-(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.

The Prison Rape Elimination Act (PREA) audit of IAH Secure Adult Detention Facility (IAH), also known as Polk, was conducted on August 3 – 5, 2021 by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Douglas K. Sproat employed by Creative Corrections, LLC. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) and Assistant Program Manager, (b) (6), (b) (7)(C) DOJ and DHS certified PREA Auditors. This facility is operated by Management & Training Corporation (MTC). Due to unforeseen circumstances, this audit report was finalized by APM, (b) (6), (b) (7)(C)

The facility processes detainees who are awaiting the results of a judicial removal review. The purpose of the August 2021 audit was to determine compliance with DHS PREA Standards. The incorporation date for the IAH was September 23, 2015. This was the second DHS PREA audit for IAH, and the audit review period included 24 months from August 2019 through August 2021. Upon completion of the audit, IAH was found to be non-compliant with five standards. The facility's Corrective Action Period (CAP) began October 21, 2021, and ended April 23, 2022.

The agency provided the Auditor the CAP in November 2021. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The 180-day CAP process ending date was April 23, 2022. The facility submitted documentation for the corrective action process from November 18, 2021, through April 7, 2022. The Auditor reviewed the final documentation submitted on April 8, 2022. The review of this documentation confirmed that all five standards are compliant in all material ways.

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. 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:

(e): MTC/IAH Policy 2.1.18 states, "From the date of the initial assessment, unless an incident of abuse or victimization occurs or when warranted based upon other relevant information each detainee shall be reassessed for their risk of victimization or abusiveness between 60 and 90 days." Intake staff should conduct reassessments for victimization or abusiveness within 60-90 days after intake or whenever needed after an incident of abuse or victimization using the ICE Custody Classification Worksheet. The average stay at IAH is 26.35 days, and none of the 10 detainee files initially reviewed by the Auditor showed a reassessment. The Auditor was furnished with a completed reassessment from the current audit cycle done on the ICE Custody Classification Worksheet so that he could verify compliance with this section of the standard. Additionally, the Auditor reviewed Mental Health documentation for one detainee involved in allegations which was submitted post audit, and although the detainee was seen by mental health following the incident, the completion of a reassessment of the detainee could not be confirmed. In an email submitted to the Auditor, following the on-site audits, the facility stated, "post allegation reassessments were not conducted for the two detainee victims as they were released less than 90 days after the alleged incidents."

Does Not Meet (e): The facility was unable to provide documentation supporting a reassessment was conducted following an incident of abuse or victimization for the two detainee victims involved in the sexual abuse allegations. To become compliant the facility must provide, if available, a sample of sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse. In addition, the facility must provide confirmation that both the classification staff and investigators have received training regarding the requirement to complete the reassessment following an incident of sexual abuse or victimization.

Corrective Action Taken (e): The facility provided the Auditor with an updated "PREA Risk Assessment Training" document that has been revised to include both "Screening for Risk of Sexual Victimization and Abusiveness" sections and "Use of Screening Information" to include the verbiage "The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." Per documentation provided by the facility, there have been no incidents of sexual abuse during the CAP period; and therefore, they are unable to provide 10 detainee files that confirm compliance with reassessing a detainee victim following an incident of abuse or victimization. The facility is now in compliance with standard 115.41 subsection (e).

§115. 61 - Staff reporting duties

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

(d): The Intake Supervisor specifically stated that ICE decides what detainees are sent to IAH; however, in an email received post on-site audit by the Auditor, the ERO POC confirmed that the facility does not accept juveniles but they do accept vulnerable adults. An email provided post on-site audit by the faculty stated that they would report the allegation to the PCSD and the FOD thus confirming that the facility does not report the sexual abuse of a vulnerable adult to Texas Health and Human Services as is required by Texas law.

Does Not Meet (d): The facility does not have a process in place to report an allegation of sexual abuse of a vulnerable adult to Texas Health and Human Services as required by Texas law. To come into compliance with section (d) of the standard, the facility must document training of upper-level staff responsible for reporting PREA allegations to entities outside the facility in instances that require such reporting. In addition, should the facility encounter an incident of sexual abuse regarding a vulnerable adult, the facility must provide documentation that the report to Texas Health and Services as required by Texas law.

Corrective Action Taken (d): The facility provided the Auditor PREA Supervisor's Training PowerPoint, how to report a sexual abuse allegation of a vulnerable adult, and training attendance rosters. This included new guidelines regarding reporting incidents of sexual abuse involving vulnerable adults to the Texas Health and Human Services. The training was completed by all security supervisors, department heads, medical administrative staff and upper level facility administrative

personnel. Per memo provided by the facility, there have been no incidents of sexual abuse during the CAP period, and therefore, they are unable to provide copies of any sexual abuse investigations that included a vulnerable adult. The facility is now in compliance with standard 115.61 subsection (d).

§115. 65 - Coordinated response

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

Notes:

(c)(d): When a detainee victim "is transferred to another facility, IAH will inform the receiving facility of the sexual abuse incident and the victim's need for medical or social services, unless the victim requests otherwise." The PSA Compliance Manager told the Auditor she would be the person making the notification to another facility if a detainee victim was being transferred. According to a June 10, 2021, memo from the Warden, "IAH Secure Adult Detention Facility has not had an occurrence of giving a notification to a receiving facility that a victim of sexual abuse was being transferred in the year preceding the audit." The PSA Compliance Manager supplemented this information by telling the Auditor that there had been no transfers of a detainee victim to another facility during the entirety of the audit period.

Does Not Meet (c)(d): The facility's policy regarding the transfer of a detainee victim and what information is to be provided to the receiving facility does not conform to the standard. The IAH policy does not make the distinction set out in the standard for "facilities covered by subpart A or B" and facilities that are not covered by these subparts. Subpart (c) of the standard requires the sending facility to send information about the detainee victim's possible need for either medical or "social services." The only restriction here is the possibility of a law that prohibits the transmission of such information without the victim's consent. There is no mention in the IAH policy of any legal restriction on passing along the required information to another immigration facility, i.e., one covered by subpart A or B. Subpart (d) of the standard allows the victim to decide what information to pass along; that is consistent with the wording of the IAH policy, except that the IAH policy does not set out that the victim's choice to decide what information is sent to the receiving facility is applicable specifically to non-immigration facilities. The facility needs to update the policy provisions reflecting the different requirements of subpart (c) and subpart (d) of the standard. The facility must provide training to the appropriate staff on the policy updates. The facility must provide the updated policy and the documented staff training for compliance review.

Corrective Action Taken (c)(d): The facility submitted updated policy 2.1.18, Prison Rape Elimination Act (PREA), which states, "If a victim of sexual abuse is transferred between DHS immigration detention facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." Updated policy 2.1.18 further states, "If a victim is transferred between DHS immigration detention facilities or to a non-DHS facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." In addition, the facility provided training sign in sheets that confirm that first line supervisors have been trained on the new policy requirements. The facility is now in compliance with standard 115.65 subparts (c) and (d).

§115. 73 - Reporting to detainees

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

Notes:

MTC/IAH Policy 2.1.18 has provisions consistent with the requirement of this standard. After the completion of an investigation into an allegation of sexual abuse, the facility must notify the detainee whether the outcome of the investigation is considered substantiated, unsubstantiated, or unfounded. The wording of the standard says the notification is to take place if the "detainee is still in immigration detention, or where otherwise feasible…." The policy addresses the possible problem of notifying an IAH detainee who is no longer in ICE custody in this manner, "if the investigation was conducted by an outside investigative authority, IAH staff will request relevant information from such authority in order to inform the detainee." The PSA Compliance Manager explained to the Auditor that she has the responsibility of notifying the detainee of the results of an investigation if the detainee is still at IAH when the investigation concludes. If the detainee is no longer at the facility and she has a forwarding address, she forwards the notification to that address. If there is no forwarding address at IAH, she requests the address from ICE and then forwards the notification. A memo dated June 10, 2021, from the Warden states, "IAH Secure Adult Detention Facility has had no occurrence of notifying a detainee who alleged sexual abuse results of an investigation in the last 12 months." The facility provided the Auditor with a blank form for detainee notification of investigation results; the Auditor reviewed the investigative files of the two sexual abuse allegations that occurred since the last audit. Neither file contained documentation that confirmed the detainee received notification as the results of the investigation. In an email provided to the Auditor, following the on-site audit, the ERO POC indicated he could not verify that the detainees were served the actual notices.

Does Not Meet: Neither the facility nor agency could document that the two detainees involved in the reviewed investigative files were notified of the outcome of their sexual abuse allegation. To become compliant, the agency must notify a detainee as to the result of the investigation and any responsive action taken. Compliance must be demonstrated by

submitting documentation that detainees at IAH are notified as required by the standard.

Corrective Action Taken: Per documentation provided by the facility, there have been no incidents of sexual abuse during the CAP period; and therefore, they are unable to provide copies of any detainee investigative outcomes that occurred during the CAP period. The facility is now compliant with standard 115.73.

§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): MTC/IAH Policy 2.1.18 covers most, but not all, of the requirements for this standard.

Under IAH policy, the PSA Compliance Manager and the Warden "conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation to assess and improve prevention and response efforts. Such review shall ordinarily occur within 30 days of the conclusion of the investigation." Although the standard requires a written report only for substantiated or unsubstantiated allegations, facility policy appears to require a report for each incident review "to assess and improve prevention and response efforts." Those conducting the review must look at certain factors listed in both the standard and the policy: "race, ethnicity, gender identity, lesbian, gay, bisexual, transgender or intersex identification, status or perceived status, or gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility." After considering those factors, along with others listed in the policy, the reviewers should then be able to properly evaluate "whether the allegation or investigation indicate a need to change policy or practice to better prevent, detect, or respond to sexual abuse." If the reviewers do make recommendations for change, the facility "shall implement the recommendation for improvement or shall document its reasons for not doing so." The policy requires the PSA Compliance Manager to make an annual review of each year's data and any corrective actions so that the agency's attempts in "preventing, detecting, and response to sexual abuse" can be evaluated. While the language of the policy closely tracks most of the standard, the standard's timeframe for the completion of the report is 30 days; the language of the policy—that the review "shall ordinarily occur within 30 days of the investigation"—is structured more like a suggestion than a requirement. The Auditor reviewed a copy of the facility's PREA Annual Review Committee's Report dated 12/17/2020 and confirmed the facility is in compliance with section (c) of the standard.

In review of the two sexual abuse investigations that were conducted since the facility's last audit, the incident reviews included in the investigative files reflected that the reviewers considered the factors required as listed above, such as race, ethnicity, gender identity, etc. Each report indicated that there were no findings that would lead to any recommendations about changes needed in policies and practices. However, the reports do not establish whether the reviews occurred "within 30 days of the conclusion of the investigation," which is the requirement of the standard.

Does Not Meet (a): One incident review supposedly was done approximately two months before the date the investigation was closed, and the other incident review is not dated, so there is no way to determine whether it was done in a timely manner. These discrepancies or omissions may represent merely inadvertent oversights or typographical errors, but without correct dates for the end of an investigation and the date of the incident review, the Auditor is unable to determine if the facility has met the requirement for this standard. A reasonable way to address the problem would merely be to slightly revise the incident review forms to require the inclusion of the two dates. The facility needs to ensure that every incident review completed contains the date the investigation was completed, as well as the date the incident review was conducted. The facility needs to develop a process to ensure incident reviews are conducted within 30 days and training with the appropriate staff needs to be completed on the process. The facility must provide the developed process and the documented staff training for compliance review**.**

Corrective Action Taken (a): To ensure that every incident review completed contains the date the investigation was completed, as well as the date the incident review was conducted the facility has slightly revised the Incident Review Form to include the date of the review. In addition, the facility has developed a process which is included in updated Policy 2.1.18. The facility has completed documented training on the updated policy to all staff involved in the review process. Per information provided by the facility there have been no incidents of sexual abuse during the CAP period, and therefore, they are unable to provide copies of any incident reviews involving detainees that occurred during the CAP period. The facility is now compliant with standard 115.86 subsection (a).

§115. Choose an item.
Outcome: Choose an item.
Notes:

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.

Sabina Kaplan May 6, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) May 6, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) May 6, 2022
Program Manager's Signature & Date