PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	1/25/2022	**To:**	1/27/2022
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-
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-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	New Orleans Field Office
Field Office Director:	(b) (6), (b) (7)(C) (Acting)
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1250 Poydras Suite 325 New Orleans, LA 70113
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:	Jackson Parish Correctional Center (JPCC)		
Physical address:	327 Industrial Drive Jonesboro, LA 71251		
Mailing address: (if different from above)	287 Industrial Drive Jonesboro, LA 71251		
Telephone number:	318-259-4309		
Facility type:	D-IGSA		
PREA Incorporation Date:	3/19/2019		
Facility Leadership			
Name of Officer in Charge:	Phil Bickham	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	229.402
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318.259

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

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-(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)
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Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	229-402-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-259-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Jackson Parish Correctional Center (JPCC) was conducted on January 25-27, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Custom Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The audit period is March 9, 2021, through January 21, 2022The JPCC is privately owned by LaSalle Corrections and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the JPCC are from Haiti, Nicaragua, and Venezuela. The facility does not house juveniles, males, or family detainees. This was the first PREA audit for the facility located in Jonesboro, Louisiana.

During the audit, the Auditor found JPCC met 31 standards, had 2 standards (115.31 and 115.35) that exceeded, had 2 standards (115.14, 115.18) that were non-applicable, and 6 non-compliant standards (115.17, 115.22, 115.41, 115.43, 115.52 and 115.67). As a result of the facility being out of compliance with 6 standards, the facility entered into a 180-day corrective action period which began on March 18, 2022, and ended on September 14, 2022. The purpose of the of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

The Auditor received notification of the first CAP via email on April 26, 2022, from ERAU. The CAP was reviewed and approved by the auditor for the six standards that did not meet compliance during the PREA audit site visit and documentation review. The Auditor received CAP documents in May 2022 and received the final CAP documents for review in August 2022 that were provided by the facility to demonstrate compliance with these standards. This documentation was reviewed, and the Auditor determined that the facility demonstrated compliance with each of the six standards found non-compliant at the time of the site visit.

Number of Standards Met: 6

§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.41 Assessment for risk of victimization and abusiveness
§115.43 Protective custody
§115.52 Grievances
§115.67 Agency protection against retaliation

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.

§115.17 - Hiring and promotion decisions

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

Notes:

(b) Policy 2.11 requires, "The Facility when considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The facility, consistent with law, shall make its best effort to contact all prior institutional employers of any applicant for employment, to obtain information of substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. The Facility shall also impose upon employees a continuing affirmative duty to disclose any such conduct." The Auditor reviewed 10 randomly chosen employee files. Five of them were recently promoted and the Auditor observed signed affirmations that the staff member had not been involved in misconduct outlined in subpart (a). The HR staff person stated the facility, along with ICE, would request information from prior institutions where the prospective candidate was previously employed during background checks. The HR staff person also stated that as a condition of employment, each employee has a continuing affirmative duty to disclose to either her office or their supervisor any behavior outlined in subpart (a). The Auditor interviewed 12 random staff, and each was aware of this affirmative duty to report. However, the random staff interviewed indicated that they are not asked to acknowledge in writing at evaluation time that they have not been involved in behavior outlined in subpart (a) and there was no documentation to support that there is a process in place

Does Not Meet (b): The review of the employee files and the interview with the JPCC Human Resources (HR) staff person confirmed the facility is not complying with the policy or standard requirement that in written self-evaluations, conducted as part of reviews of current employees, each staff member must submit confirmation that he/she has not been involved in misconduct as outlined in subpart (a). The facility must demonstrate compliance by providing documentation for 10 random staff after implementation.

Corrective Action Taken (b): On April 13, 2022, JPCC submitted a CAP stating it had conducted a self-evaluation for each employee confirming that he/she had not been involved in any misconduct as stated in policy. They also indicated they would be conducting the required evaluation annually for all staff members. JPCC also indicated they would be providing 10 examples of staff members completing this subpart (b) annual evaluation as required in the CAP. On May 6, 2022, the facility provided examples for 10 employees who have attested to the misconduct questions using the DHS ICE form pertaining to 6 CFR Part 115.117(a). The Auditor reviewed these documents and determined that the facility has demonstrated compliance with this 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:

(e)(f) Policy 2.11 requires, "If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reporting to the Field Office Director." Additionally, when a detainee(s) is alleged to be the perpetrator, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to the Field Office Director. All perpetrators of sexual abuse or assault shall be disciplined and referred for criminal prosecution as appropriate. The interview with the Warden and PSA Compliance Manager confirmed that JPCC notifies the SDDO on every allegation. The interview with the SDDO also confirmed that whenever an allegation of sexual abuse is made at JPCC he is notified as required and is responsible to make the notifications to these ICE personnel as required by this subpart. Of the five randomly selected investigative files chosen for thorough review, the Auditor found documentation that ICE was notified in each of the incidents; however, there was no indication that the JIC was notified as required by this subpart. The interview with the SDDO confirmed that he is informed of all allegations of sexual abuse. He also stated that he is required to make all the notifications to ICE personnel. Based on the JPCC PREA Allegations spreadsheet, only 1 of the 14 allegations was reported to the Joint Intake Center (JIC). The facility made notification to ERO, but ERO did not make the JIC notification

Does Not Meet (e)(f): A review of the JPCC PREA Allegations spreadsheet indicated that the JIC was notified of only 1 of 14 allegations. The interview with the SDDO confirmed that once he is notified of an allegation of sexual abuse, he is

responsible for making the other notifications. The standard requires that incidents of sexual abuse be promptly reported to the JIC, the ICE OPR/DHS OIG, and the appropriate ICE FOD.

Corrective Action (e)(f): On May 6, 2022, JPCC submitted a CAP stating that once ERO receives notification of an allegation the SDDO on duty assigned to the New Orleans (NOL) area of responsibility will make the proper notifications and complete the SIR. An email box is in place which is distributed to all supervisors within the local area who are on duty. Notifications may be received telephonically and followed up with an email to memorialize the allegation. The Auditor did not concur with the initial CAP response as it did not indicate how SAAPI allegation notifications to JIC are made for allegations occurring at JPCC. The SDDO informed the Auditor during the site visit that he makes all notifications of SAAPI incidents to the JIC but the excel spreadsheet indicated in 13 instances JIC was not notified. The Auditor requested ICE submit documentation identifying the staff responsible for making JPCC SAAPI allegation notifications to the JIC and submit documentation for five allegation notifications which may occur during the CAP. The Auditor reviewed the memorandum from the OIC to all ERO staff assigned to the JPCC regarding 'Proper Reporting of Sexual Abuse Allegations.' This document directs staff to promptly report incidents of sexual abuse to the JIC, ICE OPR/DHS OIG, and the NOL FOD in accordance with policy and through their chain of command. Additionally, the facility advised that there have been no reported allegations during the CAP period. The Auditor accepts this action as demonstration of compliance with 115.22.

§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) Policy 2.11 requires, "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." The interview with the HSA confirmed that the medical staff perform the second reassessment and any special assessments beyond the initial performed upon arrival. She also confirmed the vulnerability reassessment is completed prior to the 30th day after the initial assessment. The Auditor reviewed five medical files and found reassessments completed around day 30 of the detainee being at JPCC, instead of within 60–90 days of the initial reassessment. In addition, the facility was unable to provide documentation that a risk assessment was performed on any of the five detainees alleging sexual abuse whose investigative files were reviewed by the Auditor.

Does Not Meet (e): The Auditor's review of five medical files discovered reassessments are completed around day 30 of the detainee being at JPCC. The form that JPCC uses for the reassessment states 30-day reassessment instead of the 60–90-day reassessment the standard and policy require. Furthermore, there was no risk assessment performed on detainees alleging sexual abuse as required by subpart (e). The facility needs to follow both the DHS PREA standard and their 60–90-day policy requirement. To meet compliance, the facility needs to perform a reassessment on all detainee victims and alleged abusers as required by Policy 2.11 and the standard after an incident of sexual abuse; provide the Auditor at least one completed assessment performed on an alleged abuser and victim after the initial audit period; and provide the Auditor with 10 (60-90) reassessments completed after implementation of the updated procedures.

Corrective Action Taken (e): On April 13, 2022, JPCC submitted a CAP stating JPCC had changed the PREA Screening form of 30-day reassessment to 60–90-day reassessment to align with requirements of the policy and standard. JPCC completed 2 additional 60–90-day reassessment and provided to the Auditor for compliance review. The Auditor requested 4 additional 60–90-day reassessments and requested the JPCC address the deficiency where the facility failed to conduct reassessments on detainee victims and abusers involved in sexual abuse allegations. On September 13, 2022, the Auditor reviewed six 60–90-day reassessments JPCC completed; however there were no allegations reported within the CAP period for the facility to provide additional reassessments post allegation. The facility advised they will continue to meet the requirements to assess any detainee (alleged abuser and victim) that has had an incident of abuse or victimization. The Auditor accepts this information as demonstration that the facility is now fully compliant with standard 115.41.

§115.43 - Protective custody

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

Notes:

(d) This subpart requires written procedures directing a supervisory staff member conduct a review within 72 hours of a detainee's placement in segregation to determine whether segregation is still warranted, and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in Administrative Segregation and every week thereafter for the first 30 days and every 10 days thereafter. The policy 2.11 only requires, "every 30 days, the facility shall afford each such a review to determine whether there is a continuing need for separation from the general population."

Does Not Meet (d): The facility needs to update their written procedures, 2.11 policy, to reflect the subpart (d) requirements directing a supervisory staff member to conduct a review within 72 hours of a detainee's placement in segregation to determine whether segregation is still warranted and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in Administrative Segregation and every week thereafter for the first 30 days and every 10 days thereafter. Once the procedures have been revised, supervisory staff shall be trained on the new policy and documentation should be provided to the Auditor for compliance review.

Corrective Action Taken (d): The CAP documentation provided to the Auditor on May 2, 2022, indicated JPCC had updated the 2.11 policy to reflect the subpart (d) requirements of 115.43. The facility also provided the Auditor with the training roster containing 37 staff signatures of those attending this policy update. The facility is now compliant with the standard.

§115.52 - Grievances

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

Notes:

(e) This subpart requires the facility issue a decision on the grievance within 5 days of receipt and respond to an appeal within 30 days. Policy 2.11 states, "A Final decision shall be issued on the merits of any portion of the grievance alleging Sexual Abuse within 90 days of the initial filing of the grievance." The Grievance Officer confirmed the 90 days of the initial filing. This subpart also requires the AFOD be notified of the grievance and the decision. The policy does not address this notification and the Grievance Officer was uncertain of how he is notified.

Does Not Meet (e): The facility must update their policy to conform to the subpart requirement of the facility issuing a decision on the grievance within 5 days of receipt and responding to an appeal within 30 days. The policy also must address the AFOD notification of the grievance and the decision. The Auditor will need to review the updated policy and documented training of the Grievance Officer with the new policy requirements for compliance determination.

Corrective Action Taken (e): The May 5, 2022, CAP documentation provided to the Auditor included the updated policy 2.11, which included the addition of subpart (e) requirements. The facility also provided a Record of Training signed by the instructor and the grievance coordinator indicating that training was received on the revised Grievance System on April 4, 2022. The facility has demonstrated compliance with this standard.

§115.67 - Agency protection against retaliation

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

Notes:

(b)(c) Policy 2.11 requires "For at least 90 days following a report of sexual abuse, the Chief of Security shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. The Chief of Security shall monitor any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. DHS shall continue to monitor beyond 90 days for retaliation whenever a continuing need." The interview with the PSA Compliance Manager confirmed that JPCC has a form to document retaliation but has not monitored for any retaliation of staff or detainee. The review of the investigative files had no retaliation monitoring documented.

Does Not Meet (b)(c): The facility must employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. To meet compliance, the facility shall document retaliation monitoring following every allegation of sexual abuse employing requirements of subpart (b) and policy 2.11 requirements. The Auditor will need to verify retaliation monitoring for staff, as well as detainees, with at least five examples of completed retaliation monitoring. Additionally, the facility shall provide refresher training to the employees designated as retaliation monitors of the requirements outlined in this standard and policy 2.11 and provide documentation of completion.

Corrective Action Taken (b)(c): The May 5, 2022, CAP documentation provided to the Auditor included documentation of staff receiving training on retaliation monitoring to include the subpart (b)(c) requirement. The facility had no allegations to demonstrate compliance at this time and the Auditor requested they wait additional time during the CAP to see if the facility could demonstrate compliance of monitoring. During the review of documentation on September 13, 2022, the facility advised the Auditor they had no allegations during the CAP period. The facility advised they will meet the standard requirements to monitor any detainee or staff with any allegation of sexual abuse. The Auditor accepts this information as demonstration that the facility is now fully compliant with the standard.

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

Thomas Eisenschmidt September 15, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) September 26, 2022
Assistant Program Manager's Signature & Date

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Jackson Parish Correctional Center (JPCC) was conducted on January 25-27, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Custom Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards from March 19, 2019 (the facility's DHS PREA incorporation date) through January 21, 2022. The JPCC is privately owned by LaSalle Corrections and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the JPCC are from Haiti, Nicaragua, and Venezuela. The facility does not house juveniles, males, or family detainees. This was the first PREA audit for the facility located in Jonesboro, Louisiana.

On January 25, 2022, an entrance briefing was held in the JPCC staffing conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing and then turned it over to the Auditor. In attendance were:

LaSalle Corrections Staff
Phil Bickham, Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) Health Service Administrator (HSA)
(b) (6), (b) (7)(C) PSA Compliance Manager
(b) (6), (b) (7)(C) Food Service Manager
(b) (6), (b) (7)(C) LaSalle Management Company (LMC), Compliance Manager
(b) (6), (b) (7)(C) Compliance Manager

ICE Staff
(b) (6), (b) (7)(C), Inspection and Compliance Specialist (ICS), ICE/OPR/ERAU
(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU

Creative Corrections
Thomas Eisenschmidt - Certified PREA Auditor

The Auditor introduced himself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation for review, and conducting both staff and detainee interviews.

Approximately four weeks prior to the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, allegations spreadsheet and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA at JPCC is 2.11 Sexual Abuse and Assault Prevention and Intervention (SAAPI). All documentation, policies, and the PAQ were reviewed by the Auditor prior to the site visit. A tentative daily schedule was provided by the Lead Auditor for the interviews with staff and detainees. The Auditor received no correspondence from any detainees or staff prior to the audit or prior to the submission of the report.

Facility Description
JPCC, located in Jonesboro, Louisiana is a low, medium, and high custody adult female IGSA facility operated by LaSalle Corrections. The facility housed both male and female detainees, during part of the audit period, until it switched to female detainees only in April 2021. Because of the change in population type within the prior 12 months, the facility housed both male and female detainees for part of the year. The average population was 434 (313-males, 121-females). The facility, with a rated capacity of 1215 detainees, had 264 female detainees present on the first day of the audit. It should be noted that the JPCC facility changed management, from the Jackson Parish Sheriff's Office (JPSO) to LaSalle Corrections in December 2020, so the Auditor's review efforts were focused most on that time period through the end of the audit period. Documentation for most records, including most investigations, was secured and taken by the Sheriff investigators and not shared with the LaSalle staff once they assumed operational responsibilities for JPCC. Most files for the audit period that existed prior to this December 2020 date were unavailable for the Auditor to review. The facility has 13 dorm housing units with each dorm containing 6 showers. Dorm style housing is the type of housing available at JPCC, except for the 14 segregation cells. (b) (7)(E) (b) (7)(E) All detainees arriving at JPCC come through the facility Sallyport and then are moved to the detainee

processing area. The detainee in-processing area consists of two very large rooms. The detainees remain in this area until they are individually classified and receive a risk assessment and then are placed under quarantine for 14 days. The 14 segregation cells are also utilized for suicide watch, if needed, as the medical unit has no infirmary beds.

During the site visit, the Auditor observed signage requiring cross gender staff to announce themselves prior to entering the living areas. There is always a female staff member in each of the housing dorms areas. When a male staff member needs to enter the detainee living area, a female staff member enters the living area first, and informs the detainees that a male will be entering the area. The male does not enter the area, unless there is an emergency, until the female lets him know it is appropriate to enter. The Auditor observed this procedure during the three-day site visit. According to the PAQ and the interview with the PSA Compliance Manager, the staff compliment at JPCC is all LaSalle employees. There are 80 security staff, 27 Medical Staff, and 4 Mental Health Staff. At the time of the site visit, there were no volunteers or contractors working with the ICE detainee population. The Warden, Human Resources (HR) staff member and the PSA Compliance Manager indicated JPCC has no unescorted contractors at the facility. The only contractors that they have (Pest Control, Fire Services, etc.) are always escorted by security staff. Due to Covid-19, there have been no volunteers at JPCC for over two years.

At the conclusion of the tour, the Auditor was provided with staff and detainee rosters. Randomly selected personnel from each list were chosen to participate in formal interviews. The auditor interviewed 12 random security staff including first-line supervisors and 15 specialized staff. The specialized staff included: The Warden, PSA Compliance Manager, Human Resources, Training Supervisor, Intake staff (2), Administrative Investigator, Grievance Coordinator, Classification Supervisor, Victim Advocates (2), Supervisory Detention and Deportation Officer (SDDO) (1), Medical staff (2), and Mental Health staff. A total of 20 random detainees were interviewed as well. All 20 detainees were limited English proficient (LEP) and required the use of a language line through Language Services Associates (LSA), provided by Creative Corrections. There was no transgender, gay, bisexual, or intersex detainees available for interview at the time of the site visit. The Auditor also interviewed two detainees who disclosed prior victimization during their risk assessment.

The Auditor was provided, by the Team Lead, an Excel spreadsheet, indicating JPCC had 14 allegations of sexual abuse during the audit period. Of the 14 reported allegations, 2 were staff-on-detainee and 12 were detainee-on-detainee. All 14 allegations were investigated, and the cases closed. The two cases involving staff were determined to be one unfounded and the other unsubstantiated. Of the 12 detainee-on-detainee allegations, 11 were determined to be unsubstantiated and 1 unfounded at the conclusion of the investigations. The Auditor conducted a cursory review of all 14 investigative files to randomly check: if the investigation was conducted by a trained investigator; to ensure the detainee was seen by medical; to verify if the allegation was referred to law enforcement and to verify if the case was reported to ICE. JPCC notified ICE and the JPSO based on the provided documentation. The files that existed prior to Lasalle taking over operations at JPCC did not contain all required paperwork and the Auditor was unable to verify training for the Investigator(s) as those files went with the JCSO. The Auditor also did a thorough review of five randomly chosen investigative files.

During the site visit, the Auditor also reviewed 10 employee HR files, 10 employee training files (1-Volunteer, 2-Medical and 7-Staff), 11 detention files and 5 detainee medical files.

On January 27, 2022, an exit briefing was held in the JPCC staffing conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing and then turned it over to the Auditor. In attendance were:

<u>LaSalle Corrections Staff</u>
Phil Bickham, Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) Corporate Compliance
(b) (6), (b) (7)(C) Lieutenant
(b) (6), (b) (7)(C) Compliance Manager
(b) (6), (b) (7)(C), Human Resources
(b) (6), (b) (7)(C) Director of Nursing (DON)
(b) (6), (b) (7)(C) Food Service Manager
(b) (6), (b) (7)(C) Maintenance Supervisor
(b) (6), (b) (7)(C) PSA Compliance Manager
(b) (6), (b) (7)(C) Lieutenant
(b) (6), (b) (7)(C) Major
(b) (6), (b) (7)(C) Lieutenant
(b) (6), (b) (7)(C) Lieutenant
(b) (6), (b) (7)(C) Law Library
(b) (6), (b) (7)(C) LMC, Compliance Manager

ICE Staff
(b) (6), (b) (7)(C) SDDO, ICE/ERO
(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU
(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU

Creative Corrections
Thomas Eisenschmidt - Certified PREA Auditor

The Auditor spoke briefly about the staff and detainee knowledge of the JPCC PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit, and that he would need to discuss his findings and review interviews conducted (staff and detainee). The Auditor explained the audit report process, timeframes, and thanked all present for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2
§115.31 Staff training
§115.35 Specialized training: Medical and Mental Health Care

Number of Standards Not Applicable: 2

§115.14 Juvenile and family detainees
§115.18 Upgrades to facilities and technologies

Number of Standards Met: 31

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations

§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.42 Use of assessment information
§115.51 Detainee reporting
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.71 Criminal and Administrative Investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection

Number of Standards Not Met: 6

§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.41 Assessment for risk of victimization and abusiveness
§115.43 Protective custody
§115.52 Grievances
§115.67 Agency protection against retaliation

PROVISIONS

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

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

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

Notes:

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 2.11 (Sexual Abuse and Assault Prevention and Intervention (SAAPI) that requires, "Jackson Parish maintain a zero-tolerance policy for all forms of sexual abuse or sexual harassment in compliance with applicable standards including National Standards to Prevent, Detect, and Respond to Prison Rape under the Prison Rape Elimination Act; measures are taken to prevent sexual abuse or assault, including the designation of specific staff members responsible for staff training and detainees education regarding issues pertaining to sexual assault; procedures for immediate reporting of any allegations of sexual abuse or assault through chain of command procedures, and to ICE/ERO including written documentation requirements; procedures for detainees to report allegations; measures taken for prompt and effective intervention to address the safety and medical/mental health treatment needs of detainee victims, and to preserve and collect evidence; procedures for referral of incidents to appropriate investigative law enforcement agencies and OPR, and coordination with such entities; disciplinary sanctions for staff, up to and including termination when staff has violated agency sexual abuse policy; and data collection and reporting." The PSA Compliance Manager provided the Auditor written verification that policy 2.11 was approved by the ICE acting Assistant Field Office Director (AFOD).

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 2.11 that requires, "The Facility Administrator will designate a Prevention of Sexual Assault Compliance Manager POC for ICE and PSA (PSA Coordinator) who will serve as the facility point of contact for the ICE PSA Coordinator and who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures." At JPCC, Ms. A. Garcia, has been designated as the PSA Compliance Manager. During her interview, she indicated she is the point of contact for the agency's PREA Coordinator, she has sufficient time and authority to oversee efforts for the facility to comply with the JPCC zero-tolerance policy and reports to the Warden on all things PREA related. The Warden also confirmed the PSA Compliance Manager reports directly to him during his interview. The facility provided an organizational chart revised on 03/01/2022 and the PSA Compliance Manager position is identified on the chart.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) The Auditor determined compliance with this subpart of the standard based on review of policy 2.11 that requires, "the Facility will maintain sufficient supervision of detainees through a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall review annually and take into consideration: Generally accepted detention and correctional practices; Any judicial findings of inadequacy; Any findings of inadequacy from Federal investigative agencies; Any findings of inadequacy from internal or external oversight bodies: All components of the facility's physical plant (including "blind-spots" or areas where staff or inmates may be isolated); The composition of the inmate population; The number and placement of supervisory staff; Institution programs occurring on a particular shift; Any applicable State or local laws, regulations, or standards and the prevalence of substantiated and unsubstantiated incidents of sexual abuse." The Auditor was provided JPCC's supervision guidelines for each shift and the most recent (December 1, 2021) detainee supervision review, which reflected the review was conducted assessing the subpart (c) requirements. There were no recommendations for changes to policy or operations in this review. During the three days the Auditor was on-site he observed, on each of the twelve-hour shifts, adequate supervision of the detainees.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 2.11 that requires, "The Chief of Security shall ensure the Shift Supervisor or designee is conducting weekly rounds and documenting PREA unannounced rounds. Both day and evening shift supervisors, while conducting these rounds shall be looking at cross-gender viewing, gender announcement, staff-detainee communication, identify and deter sexual abuse of detainees and ensuring PREA signs are posted in housing areas and holding rooms. Employees are prohibited from alerting other employees that these supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the Facility." The Auditor randomly reviewed logbooks in areas detainees have access to while on-site and found supervisor signatures on different shifts daily indicating that PREA rounds are being made. The interviews with the shift supervisors (4) confirmed they make rounds in every location, staggering times, and locations. The interviews with eight (8) random security line staff confirmed they were aware of the policy prohibiting them from alerting other staff that supervisors were making rounds.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

JPCC does not accept juveniles or family detainees. This was confirmed in the PAQ and with interviews conducted with the Warden, PSA Compliance Manager, and the Auditor's personal observations while on-site.

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

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

Notes:

(b) This subpart is not applicable as JPCC is an adult female facility.

(c)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "The Facility shall not conduct cross-gender pat-down searches of female detainees unless in exigent circumstances. The Facility shall document all cross-gender strip searches, cross-gender visual body cavity searches, and all cross-gender pat-down searches." The Auditor interviewed 12 security staff (male and female) who acknowledged cross-gender pat-down searches are not permitted at JPCC except in exigent circumstances. The Auditor received documentation from the PSA Compliance Manager indicating that cross-gender pat-down searches were not conducted at JPCC during the audit period. The Auditor also reviewed the search training curriculum provided to JPCC security staff that covered these subpart requirements, as well as 10 random security training files documenting that search training was received.

(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "The Facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances including consideration of officer safety, or when performed by medical practitioners. The Facility shall document all cross-gender strip searches, cross-gender visual body cavity searches, and all cross-gender pat-down searches." The PSA Compliance Manager and the Warden confirmed the facility had no instances of cross-gender strip searches or body cavity searches conducted during the audit period. The Auditor also reviewed the search training curriculum provided to JPCC security staff, that covered these subpart requirements, as well as 10 random security training files documenting this that search training was received. The random security staff (12) interviews confirmed the no cross gender strip and body cavity searches, and also confirmed same gender strip searches must be approved by the Warden. An interview with the Warden further confirmed there were none completed during the audit period.

(g) The Auditor determined compliance with this subpart of the standard based on review of policy 2.11 that requires, "The Facility shall enable detainees to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine dorm checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. The Facility shall require staff of the opposite gender to announce their presence when entering a detainee-housing unit." There is always a female security staff member assigned to each of the housing unit areas. Prior to a male staff member entering the female detainee living area, a female staff member must enter and inform the detainees a male will be entering. Once the unit is prepared, the male staff member is allowed to enter. This is the practice in each housing unit unless entrance is necessary for an emergency. The Auditor observed this practice and was informed by each of the 20 random detainees interviewed that this is done consistently at their units. The interviews with the 12 random security staff confirmed this practice and the Auditor randomly picked 5 recent shift post assignments (night and days) and verified that on those dates at least once female was assigned in each detainee housing unit.

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

(i)(j) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires "The Facility shall not search or physically examine a transgender or intersex detainee for the sole purpose of determining the detainee genital status. If the detainee's genital status is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of the standard medical examination that all detainees must undergo as part of the intake or other processing procedures conducted in private by a medical practitioner. The Facility shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex detainees, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs." The Auditor reviewed the JPCC training curriculum for searches. Both (i)(j) subparts were specifically addressed in the curriculum. The 10 random security training files documented the staff members' participation. During the 12 random security staff interviews, each confirmed their knowledge of the prohibition of searching detainees to determine their genital status and their responsibility to perform all pat-down searches in a professional and respectful manner. They also confirmed the search training they received included cross gender, transgender and intersex searching techniques. At the time of the audit site visit, there were no transgender or intersex detainees present at the facility to interview.

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

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "The Facility shall ensure detainees with disabilities (including, detainees who are deaf or hard of hearing, those who are blind or have low

vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Facility will ensure effective communication with detainees who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. The Facility shall ensure that written materials are provided in formats or through methods that ensure effective communication with detainees with disabilities, including detainees who have intellectual disabilities, limited reading skills, or who are blind or have low vision. JPCC is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the ADA, 28 CFR35.164. The Facility will take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to detainees who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In matters relating to allegations of sexual abuse, the Facility shall provide in person or telephonic interpretation services that enable effective, accurate, and impartial interpretation by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the facility determines that such interpretation is appropriate and consistent with DHS policy. JPCC prohibits the provision of interpreter services by minors, alleged abusers, detainee who witnessed the alleged abuse, and detainee who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse."

The interview with the JPCC intake staff member confirmed that every detainee arriving at JPCC is provided and signs for the LaSalle Corrections Jackson Parish Correctional Center Handbook available in English and Spanish, the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) and the DHS-prescribed Sexual Assault Awareness Information pamphlet in nine languages (English, Spanish, Arabic, Chinese, French, Haitian Creole, Hindi, Portuguese, and Punjabi). She also informed the Auditor when she is confronted with a detainee that may be hearing impaired or deaf, that information is provided to them in writing or through use of the facility text telephone (TTY). She also indicated that when confronted with detainees who are blind or with limited sight that she, or another staff member, would provide individualized instruction to include reading information to the detainee if needed. She also informed the Auditor that when dealing with a detainee with low intellect or limited reading skills that she has and would continue to notify her supervisor, medical, or mental health staff if she was unable to present information to the detainee that they could understand based on the detainee's limitation. The Auditor interviewed 20 randomly chosen detainees that were LEP during the on-site visit. Eleven of them indicated they were not provided information on sexual safety in a format they understood upon arrival. The Auditor reviewed their detention files and found signed receipts for the documents the intake staff member indicated are provided to each of them upon arrival. There were no detainees with any other disabilities present at the JPCC at the time of the site visit for the Auditor to interview. The random staff interviews (12) confirmed their understanding of who can and cannot provide interpretation services during matters relating to sexual abuse as outlined in subpart (c). The interviews with the PSA Compliance Manager and the Investigator confirmed an interpreter would be used in any investigation of alleged sexual abuse involving a LEP detainee. An interpreter was required for 9 of the 14 allegations; interpreter services were performed by staff in all nine investigations.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11, Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive, which detail suitability requirements for candidate hirings. Policy 2.11 states, "The Facility is prohibited from hiring anyone who may have contact with detainees, and shall not enlist the services of any contractor/volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity."

The acting Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in November 2021, about candidate suitability for all applicants to include their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. The Auditor reviewed 10 employee files and found ICE approvals to hire the staff member prior to their actual start date as well as a signed self-declaration that the employee had not engaged in behavior outlined in subpart (a) as a condition for hiring.

Policy 2.11 requires, "The Facility when considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The facility, consistent with law, shall make its best effort to contact all prior institutional employers of any applicant for employment, to obtain information of substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. The Facility shall also impose upon employees a continuing affirmative duty to disclose any such conduct." The Auditor reviewed 10 randomly chosen employee files. Five of them were recently promoted and the Auditor observed signed affirmations that the staff member had not been involved in misconduct outlined in subpart (a). The HR staff person stated the facility, along with ICE, would request information from prior institutions where the prospective candidate was previously employed during background checks. The HR staff person also stated that as a condition of employment, each employee has a continuing affirmative duty to disclose to either her office or their supervisor any behavior outlined in subpart (a). The Auditor interviewed 12 random staff, and each was aware of this affirmative duty to report. However, the random staff interviewed indicated that they are not asked to acknowledge in writing at evaluation time that they have not been involved in behavior outlined in subpart (a) and there was no documentation to support that there is a process in place.

Does Not Meet (b): The review of the employee files and the interview with the JPCC Human Resources (HR) staff person confirmed the facility is not complying with the policy or standard requirement that in written self-evaluations, conducted as part of reviews of current employees, each staff member must submit confirmation that he/she has not been involved in misconduct as outlined in subpart (a). The facility must demonstrate compliance by providing documentation for 10 random staff after implementation.

(c)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "The Facility shall conduct criminal background checks and make its best effort to contact prior institutional employers to obtain information on substantiated allegations of Sexual Abuse or any resignation pending investigation of an allegation of Sexual Abuse, prior to hiring new Employees. Background checks shall be repeated for all Employees, Contractors, and Volunteers at least every five years." The Auditor was informed by the JPCC HR Manager that ICE completes background checks for all staff prior to hiring and then again, every five years. The Training Manager conducts law enforcement background investigations on all volunteers. Based on an interview with the PSA Compliance Manager and HR Manager, JPCC currently has no contractors who may have contact with detainees but according to policy, if they enlist the services of a contractor in the future, they would conduct a background check according to the requirements of policy 2.11. The only contractors who are currently used are service contractors who are escorted by security staff at all times and do not have contact with detainees. Review of the documentation provided by the ICE OPR PSO confirmed background checks were initially conducted on the 10 randomly selected employees (8 JPCC and 2 ICE), were performed prior to them reporting to work at JPCC, and initiated within the 5-year time frame.

(e) The JPCC HR Manager confirmed that as outlined in JPCC policy 2.11, the facility would decline to hire or promote and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information.

(f) Policy 2.11 requires that "unless prohibited by law, the facility shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." The JPCC HR Manager interviewed stated the facility would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated the employee however would be required to sign a release of information document in this case.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) These subparts of the standard are not applicable at JPCC. The Warden and the PAQ confirmed the facility has not made any upgrades to the facility or to their technologies 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)(e) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "To the extent that JPCC is responsible for investigating allegations of sexual abuse; the facility shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable." Agency 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 personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or a local law enforcement agency. The OPR will coordinate with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not accepted or assigned by the (DHS) Office of the Inspector General (OIG), OPR, or local law enforcement agency, the case would be referred to ERO for assignment and completion of an administrative investigation. JPCC conducts its' own internal administrative investigations by a qualified security staff member (Investigator) who has received specialized investigative training on sexual abuse. JPCC has a Memorandum of Understanding (MOU) with the JPSO, the agency that is contacted upon every allegation of sexual abuse as the investigative agency for all criminal cases at JPCC according to the Warden, Investigator and PSA Compliance Manager. The MOU stipulates that the JPSO would adhere to subparts (a) through (d) of the standard. The 2.11 policy was approved by the AFOD. The Auditor thoroughly reviewed five investigative files for allegations of sexual abuse and determined the facility utilized the uniform evidence protocols in accordance with the standard requirement.

(b)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "The Warden shall consider how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victim's needs. The Facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified to victims of sexual assault of all ages. A qualified agency staff member or a qualified community-based staff member means an individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals. As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews." JPCC has a written MOU with WINN Community Health Center to provide victims of sexual assault emotional support, crisis intervention and information if needed. They have an unsigned agreement with Project Celebration Inc., an accredited Sexual Assault Center, to provide advocacy service, crisis hotline, forensic support and legal interview support if needed. The Auditor spoke with a representative of both agencies who validated their agencies would provide emotional support, crisis intervention and community referrals if requested. Both indicated the agency has not had any contact with detainees during the audit period. In each of the five thoroughly investigated files, the Auditor found notations that indicated detainees were informed of the victim advocate on the day of the allegation.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 2.11 that requires, "The Facility shall offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The facility shall document its efforts to provide SAFEs or SANEs. The results of the physical examination and all collected physical evidence are provided to the investigative entity." The HSA confirmed the 2.11 policy outlines the JPCC forensic protocols and indicated all services would be provided to detainee victims without cost. She also stated that forensic exams and emergency treatment services are provided at the Jackson Parish Hospital in the community. She confirmed her staff would triage the detainee and prepare her for transport. JPCC has an MOU with the Jackson Parish Hospital that agrees to provide a SAFEs or SANEs where possible. If a SAFE or SANE cannot be made available, the examination would be performed by a qualified medical practitioner at the hospital. She also indicated two forensic examinations were performed, at the Jackson Parish Hospital, on JPCC detainees during the audit period with negative findings.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "Jackson Parish shall ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for

investigation by an agency with the legal authority to conduct criminal investigations and shall document such referrals. Jackson Parish will ensure all allegations of Sexual Abuse and Sexual Harassment are referred for investigation to the JPSO to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. Facilities shall document all referrals. Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The agency shall maintain sexual abuse data collected for at least 10 years after the date of the initial collection unless Federal, State, or local law requires."

The November 2021 Auditor training confirmed all allegations, once reported to the JIC, are assessed to determine if it falls within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, 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 in 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 action, and the agency would assign an administrative investigation to be completed. JPCC had 14 allegations of sexual abuse during the audit period. Of the 14 reported investigations, 2 were staff-on-detainee and 12 were detainee-on-detainee. All 14 allegations were investigated, and the cases were closed. The two cases involving staff were determined to be one unfounded and the other unsubstantiated. Of the 12 detainee-on-detainee allegations, 11 were determined to be unsubstantiated and 1 unfounded at the conclusion of the investigations. The Auditor conducted a cursory review of all 14 investigative files to check if the investigation was conducted by a trained investigator; ensure the detainee was seen by medical; verify if the allegation was referred to law enforcement; and verify if the case was reported to ICE. The Auditor found that all of these requirements were met in accordance with the standard. JPCC notified ICE and the JPSO based on the provided documentation. However, the agency is not compliant with the requirement to report all allegations to the JIC.

(c) The Auditor determined compliance with this subpart based on the protocols for ICE investigations and LaSalle investigations being found on their respective web pages: (www.ICE.gov/prea) and (https://lasallecorrections.com/human-rights).

(e)(f) The Auditor based compliance on this subpart of the standard after review of policy 2.11 that requires, "If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reporting to the Field Office Director." Additionally, when a detainee(s) is alleged to be the perpetrator, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to the Field Office Director. All perpetrators of sexual abuse or assault shall be disciplined and referred for criminal prosecution as appropriate. The interview with the Warden and PSA Compliance Manager confirmed that JPCC notifies the SDDO on every allegation. The interview with the SDDO also confirmed that whenever an allegation of sexual abuse is made at JPCC he is notified as required and is responsible to make the notifications to these ICE personnel as required by this subpart. Of the five randomly selected investigative files chosen for thorough review, the Auditor found documentation that ICE was notified in each of the incidents; however, there was no indication that the JIC was notified as required by this subpart. The interview with the SDDO confirmed that he is informed of all allegations of sexual abuse. He also stated that he is required to make all the notifications to ICE personnel. Based on the JPCC PREA Allegations spreadsheet, only 1 of the 14 allegations was reported to the Joint Intake Center (JIC). The facility made notification to ERO, but ERO did not make the JIC notification.

Does Not Meet (e)(f): A review of the JPCC PREA Allegations spreadsheet indicated that the JIC was notified of only 1 of 14 allegations. The interview with the SDDO confirmed that once he is notified of an allegations of sexual abuse he is responsible for making the other notifications. The standard requires that incidents of sexual abuse be promptly reported to the JIC, the ICE OPR/DHS IG, and the appropriate ICE FOD.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all employees and shall also be included in annual refresher training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under this standard, and shall include: the facility's zero-tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal sexual behavior; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; and examples of prohibited and illegal sexual behavior; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in

order to make decisions concerning the detainee victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; instruction on reporting knowledge or suspicion of sexual abuse and/or assault; and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault. The Facility shall maintain written documentation verifying employee, volunteer, and contractor training." The Auditor reviewed the staff sexual abuse training curriculum and determined that it included each of the subpart (a) requirements. The Auditor reviewed nine employee training files and found written documentation verifying completion of this training and the annual refresher. The Auditor interviewed 12 random facility staff and 1 random ICE staff who verified they received initial PREA training and annual refresher. Each JPCC staff member interviewed detailed the content of the training, which coincided with the standard and policy requirements. The annual refresher training exceeds the standard requirement. The Training Supervisor provided documentation to the Auditor demonstrating all employees at the JPCC received the required PREA training for 2021 except those out on long term absence.

§115.32 - Other training.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires "The facility shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies, and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the Jackson Parish Correctional Center's zero-tolerance policy and informed how to report such incidents. In this paragraph "other contractor" means a person who provides services on a non-recurring basis to the facility pursuant to a contractual agreement with the agency or facility. The Facility shall maintain written documentation verifying employee, volunteer, and contractor training." There are no contractors utilized at JPCC. Due to the COVID-19 pandemic there were no volunteers currently at the facility either. The Auditor interviewed the Training Supervisor who indicated that contractor's (if they had them) and volunteer's PREA training curriculum is identical covering standard 115.31 subpart (a) requirements. The Auditor reviewed one volunteer training record and found a signed acknowledgement indicating the volunteer had received and understood the training.

§115.33 - Detainee education.

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

Notes:

(a)(b)(c)(e) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Detainees shall be informed about Jackson Parish Correctional Center's sexual abuse and assault prevention and intervention program and zero-tolerance policy for sexual abuse and assault through the orientation program and the detainee handbook. Detainee notification, orientation, and instruction must be in a language or manner that the detainee understands. Jackson Parish Correctional Center prohibits all forms of sexual abuse or assault staff on detainee, detainee on detainees; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, (e.g., the compliance manager or a mental health specialist) the Detention and Reporting Information Line (DRIL), the DHS Office of Inspector General, and the Joint Intake Center; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. Each detainee shall receive a copy of the "Sexual Assault Awareness Information" pamphlet; a Jackson Parish Correctional Center Detainee Handbook; and an U.S. Immigration and Customs Enforcement National Detention Handbook which both include information on how to report sexual abuse. A signed acknowledgment shall be kept in the detainee detention file. Detainee notification, orientation, and instruction must be in a language or manner that the detainee understands, including for those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. Jackson Parish Correctional Center shall maintain documentation of detainee participation in the instruction session. The Jackson Parish Correctional Center shall have a TTY machine available in the Intake Processing Area." As noted in standard 115.16, upon arrival at the JPCC, each detainee is provided and signs for a copy of the LaSalle Corrections Jackson Parish Correctional Center Handbook Supplement available in English and Spanish, the ICE National Detainee Handbook, which is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese), and the DHS-prescribed Sexual Assault Awareness Information pamphlet in 9 languages. The ICE National Detainee Handbook was reviewed, and it informs the detainee of the zero-tolerance policy against sexual abuse, defines prohibited behaviors, informs the detainee how to avoid situations leading to sexual assault, how to report allegations to include DHS, DHS OIG, the DRIL and informs the detainee about receiving medical attention. The intake staff interview confirmed if a detainee speaks a language not available through the ICE handbook, the staff will utilize the ERO Language Line Service for interpretive services to provide this initial sexual safety information found on pages 22 and 23 in this booklet. The intake staff also confirmed any detainees the facility encounters that may be hearing impaired or deaf would require staff to utilize the text telephone (TTY). Those detainees arriving at JPCC with limited sight or who are blind would be provided individualized attention by staff that may include reading the information to her. In cases where the detainee has low intellect or limited reading skills, depending on the degree of limitation, would be referred initially to a supervisor or the medical/mental health department to provide the necessary orientation information. The Auditor

reviewed 11 detention files while on site that included 11 detainees who indicated during the 20 random interviews, they had never received this orientation. One of them was an Arminian who spoke a language not covered by the ICE National Detainee Handbook languages. During her interview, she indicated she received orientation materials by a staff member through an interpreter. The other 10 detention files checked also documented, through signature, that the detainee received orientation material.

Recommendation (b): The facility does not document the specific use of the language line when providing orientation information to the detainee in a language not provided in the ICE National Detainee Handbook. Had a detainee indicated she had not received orientation information in a language not covered by this handbook, the facility would not be able to demonstrate it has used the interpreter services for this reason. The Auditor recommends that the facility document the reason the services are being used.

(d) The Auditor determined compliance with this subpart of the standard after observing the DHS-prescribed Sexual Assault Awareness zero-tolerance poster, in Spanish and English, posted throughout JPCC in all areas where detainees have access. Included on these posters was the name of the PSA Compliance Manager. Also prominently displayed and observed by the Auditor was contact information for Project Celebration Inc. and WINN Community Health Center, the victim advocates.

(f) The Auditor determined compliance with this subpart of the standard after reviewing detainee reporting information provided in LaSalle Corrections Jackson Parish Correctional Center Handbook Supplement and in the ICE National Detainee Handbook.

§115.34 - Specialized training: Investigations.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after review of the facility's policy 2.11 requires "In addition to the general training provided to all Jackson Parish Correctional Center employees, the Jackson Parish Correctional Center shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training must cover, at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria, and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The Jackson Parish Correctional Center shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations." The agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault." The lesson plan for this specialized training is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirements. The Auditor interviewed JPCC's primary Investigator. He confirmed receiving specialized training and his training was documented in his training record. The Auditor reviewed JPCC's primary Investigator's training file and found he was provided his Investigator training through the National Institute of Corrections (NIC) and it included curriculum on working with outside entities. There were 14 sexual abuse investigations conducted during the audit period. As noted in the report narrative, training records were removed from the facility for some of the investigators as a different agency took over the facility. The current Investigator is trained and the investigations, conducted since LaSalle took over operations, have been completed by a trained Investigator.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b) These subparts of the standard are not applicable to JPCC as the medical department is operated through LaSalle Corrections.

(c) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "The Jackson Parish Correctional Center shall ensure that all full and part-time medical and mental health care practitioners are provided with specialized training, to include: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; if medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. The Jackson Parish Correctional Center training department shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or from elsewhere. Medical and mental health care practitioners shall also receive the training mandated for employees under 115.31 or for contractors and volunteers under 115.32, depending upon the practitioner's status at the agency." The Auditor reviewed two medical staff training files and found their records demonstrated medical and mental health staff received the required PREA training and the specialized training on an annual basis. The interview with the HSA, and as noted in 115.21, JPCC does not conduct forensic examinations on site. Detainees requiring this service are taken to the Jackson Parish Hospital. The HSA also confirmed that all JPCC medical and mental health staff received all required training for 2021. Policy 2.11 was approved by the AFOD. The facility exceeds the standard based on medical and mental health staff receiving the training annually and the standard makes no requirement beyond the one time.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(f) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "The Jackson Parish Correctional Center shall assess all detainees upon intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. All detainees will be screened within 12 hours of their arrival at the facility for potential vulnerabilities or tendencies of acting out sexually aggressive behaviors. Housing assignments are made accordingly. Detainees identified as being at risk for sexual victimization are monitored and counseled and are placed in the least restrictive housing that is available and appropriate. The Jackson Parish Correctional Center shall also use the information to inform assignment of detainees to recreation and other activities, and voluntary work. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly. Detainees identified as having a history of sexually assaultive behavior or at risk for sexual victimization shall be assessed by a mental health or other qualified health care professional and monitored and counseled as determined by the professional. If the assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. The following criteria will be used in screening to assess detainees for risk of sexual victimization and sexual abusive behavior: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive." The JPCC Screening for Risk of Sexual Victimization and Abusiveness PREA Risk of Victimization and Abusiveness form was reviewed by the Auditor and addressed each of the requirements of subpart (c) and subpart (d), as known to the facility. The Auditor interviewed the primary intake staff member who confirmed the classification is completed within the first 12 hours of the detainees' arrival by a trained staff member. The staff member, performing the risk assessment, confirmed that assessments are typically completed within the first 2 hours of arrival. She also stated detainees are never disciplined for refusing to answer any of the assessment questions and remain in the processing area until the assessment and classification are performed. The Auditor's review of 11 detention files documented the classification and assessment being completed on the day of arrival. The facility does not document the time that the initial classification process and initial housing assignment is completed, so the Auditor is unable to verify through documentation that it is completed within 12 hours of admission to the facility; however, interviews with staff and detainees provided sufficient information to indicate to the Auditor that the processes are completed within the required timeframe.

Recommendation: The Auditor recommends that the facility add a field to document the time of admission and the time that the initial classification process and initial housing assignment is completed to better ensure compliance with subpart (b), requiring that these actions be completed within 12 hours of admission to the facility.

(e) Policy 2.11 requires, "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." The interview with the HSA confirmed that the medical staff perform the second reassessment and any special assessments beyond the initial performed upon arrival. She also confirmed the vulnerability reassessment is completed prior to the 30th day after the initial assessment. The Auditor reviewed five medical files and found reassessments completed around day 30 of the detainee being at JPCC, instead of within 60 – 90 days of the initial reassessment. In addition, the facility was unable to provide documentation that a risk assessment was performed on any of the five detainees alleging sexual abuse whose investigative files were reviewed by the Auditor.

Does Not Meet (e): The Auditor's review of five medical files discovered reassessments are completed around day 30 of the detainee being at JPCC. The form that JPCC uses for the reassessment states 30-day reassessment instead of the 60–90-day reassessment the standard and policy require. Furthermore, there was no risk assessment performed on detainees alleging sexual abuse as required by subpart (e). The facility needs to follow both the DHS PREA standard and their 60–90-day policy requirement.. To meet compliance, the facility needs to perform a reassessment on all detainee victims and alleged abusers as required by policy 2.11 and the standard after an incident of sexual abuse; provide the Auditor at least one completed assessment performed on an alleged abuser and victim after the initial audit period; and provide the Auditor with 10 (60-90) reassessments completed after implementation of the updated procedures.

(g) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "The Jackson Parish Correctional Center shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this screening in order to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees." The Auditor observed control over the intake process paperwork until the documents were finally retained under lock and key in the medical unit. The Auditor's interviews with the intake staff and random staff confirmed information they become aware of during the risk screening process is to remain confidential.

§115.42 - Use of assessment information.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "Screening Information from the risk screening [is] required to inform housing, bed, work assignments within the Facility in order to keep potential victims away from potential abusers. Detainees identified as being [at] risk for sexual [victimization] are monitored and counseled and placed in [the] least restrictive housing that is available and appropriate." The Auditor reviewed five detainee medical files and observed where the initial assessment and reassessment files are kept. The files reviewed demonstrated individualized assessments were conducted on each detainee to ensure her safety. The interviews with one of the intake staff responsible for conducting the initial assessment, and the medical staff member who conducts the reassessment, confirmed all bed, limited work, and programing assignments are based on each detainees' individualized assessment to ensure the safety of the detainee. The 20 random detainee interviews confirmed each of their assessments were individualized and completed prior to their beds being assigned.

(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "In making assessment and housing assignments, for Transgender and Intersex detainees Jackson Parish Correctional Center shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. Medical and mental health professionals shall be notified as soon as practicable on this assessment. The Facility shall not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. The Jackson Parish Correctional Center placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee. LGBTI Individuals in the Facility shall not be placed in housing units solely based on their identification as LGBTI, unless such dedicated unit exists in connection with consent decree, legal settlement, or legal judgment for the purpose of protecting such detainee." There was no transgender or intersex detainee at JPCC during the on-site visit. The facility has not had a transgender or intersex detainee during the audit period. The interview with both the HSA and a mental health practitioner confirmed ICE typically notifies JPCC of any incoming transgender or intersex detainees prior to them arriving at the facility. They indicated whenever a transgender or intersex detainee arrives the detainee appears before a medical and mental health practitioner prior to a decision on housing, taking into account factors to best meet the safety and security needs of the detainee, including allowing for transgender and intersex detainees to shower separately from other detainees. There was no paperwork for the Auditor to review documenting the assessment process and bedding assignment for any transgender or intersex during the on-site visit.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Detainees at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If the facility cannot conduct such an assessment immediately, the facility may hold the detainee in involuntary segregated housing for less than 24 hours while completing the assessment. The facility shall assign detainees to involuntary segregated housing only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. If an involuntary segregated housing assignment is made [for this purpose] the facility shall clearly document: The basis for the facility's concern for the detainees' safety; and the reason why no alternative means of separation can be arranged. Every 30 days, the facility shall afford each such a review to determine whether there is a continuing need for separation from the general population. Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If the facility restricts access to programs, privileges, education, or work opportunities, the facility shall document: the opportunities that have been limited; the duration of the limitation; and the reasons for such limitations. The Facility shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours." The Warden, Assistant Warden and PSA Compliance Manager all stated that the placement of any vulnerable detainee in administrative segregation is not typically done at JPCC. The Warden stated that no detainee vulnerable to victimization has been placed in segregation during the audit period. He also indicated he would move the detainee to another housing unit, to the intake processing area, or contact the AFOD to transfer the detainee. If segregation were to be used, he stated the policy requirements related to the standard would be followed. Policy 2.11 was reviewed and signed by the AFOD.

(d) This subpart requires written procedures directing a supervisory staff member conduct a review within 72 hours of a detainee's placement in segregation to determine whether segregation is still warranted, and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in Administrative Segregation and every week thereafter for the first 30 days and every 10 days thereafter. The policy 2.11 only requires, "every 30 days, the facility shall afford each such a review to determine whether there is a continuing need for separation from the general population."

Does Not Meet (d): The facility needs to update their written procedures, 2.11 policy, to reflect the subpart (d) requirements directing a supervisory staff member to conduct a review within 72 hours of a detainee's placement in segregation to determine whether segregation is still warranted and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in Administrative Segregation and every week thereafter for the first 30 days and every 10 days thereafter.

Once the procedures have been revised, supervisory staff shall be trained on the new policy and documentation should be provided to the Auditor for compliance review.

§115.51 - Detainee reporting.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of policy 2.11 that requires, "The Facility shall ensure that detainees have multiple ways for detainees to privately report sexual abuse and sexual harassment, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. JPCC shall provide instructions on how detainees may contact their consular official, the DHS Office of the Inspector General or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents. The Facility has one way for detainees to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward detainee reports of sexual abuse and sexual harassment to agency officials, allowing the detainees to remain anonymous upon request. Detainees shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security." The Auditor placed a call to the OIG reporting number and the DRIL from three different housing locations and completed the call. In all cases, the connection did not require the use of a detainee PIN. This information is located above the reporting information provided to the detainee upon arrival in the ICE National Detainee Handbook (in 14 languages) and prominently displayed in each of the living areas in Spanish and English, noting anonymous reporting, on the ICE and DHS posters. The interview with the PSA Compliance Manager confirmed each detainee arriving at JPCC receives this contact and reporting information during their orientation materials provided at intake. As noted in standards 115.16 and 115.33, the Auditor interviewed 20 randomly chosen detainees that were LEP during the on-site visit. Eleven of them indicated they were not provided information on sexual safety and reporting in a format they understood upon arrival. The Auditor reviewed their detention files and found signed receipts for these documents for each of them. The Auditor asked each, during their interviews, through an interpreter if they knew how to report an allegation of sexual abuse if needed for themselves or someone else and they indicated they were aware.
(c) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "Employees shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports." The Auditor interviewed 12 random staff who confirmed the facility policy requirement that they are to accept and report allegations of sexual abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors. Of the 14 allegations of sexual abuse investigated during the audit period, one was reported through an ICE employee and the remainder made to JPCC security staff. The Auditor thoroughly reviewed five investigative files during the audit period. Each of the five reviewed included verbal allegations reported to security staff members who immediately reported it to a supervisor and documented the allegation in writing.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(f) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Detainees have the right to submit grievances alleging Sexual Abuse to someone other than the alleged abuser. Such grievance is not referred to the staff member who is subject of the complaint. Detainees are not required to use any informal grievance process or attempt to resolve with Employees an alleged incident of Sexual Abuse. No time limits will be set when a detainee may submit a grievance regarding an allegation of Sexual Abuse or Sexual Assault. The Facility staff shall be responsible on identifying and [handling] time-sensitive grievances that involve an immediate threat to detainees, health, safety, or welfare related to sexual abuse. Third parties (e.g., fellow detainees, Employees, family members, attorneys and outside advocates) may assist individual's detainees in filing requests for administrative remedies relating to allegations of Sexual Abuse and Sexual Harassment and may […] file such requests on behalf of the alleged victim. The alleged victim must agree to have the request filed on his or her behalf; however, he/she is not required to personally pursue any subsequent steps in the administrative remedy process; if the detainee declines to have the request processed on his or her behalf, the facility shall document the detainee's decision." The Auditor interviewed the Grievance Supervisor who confirmed all allegations of sexual abuse, made through the grievance office, are immediately reported to the PSA Compliance Manager and Facility Administrator. The alleged detainee victim is immediately taken to medical for assessment. He also stated there would be no time limit on when the detainee could file a grievance alleging sexual abuse. The Grievance Officer confirmed that JPCC had no allegations of sexual abuse made through the grievance system by a detainee during the audit period.

(e) This subpart requires the facility issue a decision on the grievance within 5days of receipt and respond to an appeal within 30 days. Policy 2.11 states, "A Final decision shall be issued on the merits of any portion of the grievance alleging Sexual Abuse within 90 days of the initial filing of the grievance." The Grievance Officer confirmed the 90 days of the initial filing. This subpart also requires the AFOD be notified of the grievance and the decision. The policy does not address this notification and the Grievance Officer was uncertain of how he is notified.

Does Not Meet (e): The facility must update their policy to conform to the subpart requirement of the facility issuing a decision on the grievance within 5 days of receipt and responding to an appeal within 30 days. The policy also must address the AFOD notification of the grievance and the decision. The Auditor will need to review the updated policy and documented training of the Grievance Officer with the new policy requirements for compliance determination.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance on these subparts of the standard after a review of policy 2.11 that requires, "The Facility shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse perpetrators to most appropriately address victim's needs. [The facility] shall make available to the fullest extent possible, outside victim services following incidents of sexual abuse. The Facility shall also attempt to make available such victim services for any individuals identified as having experienced sexual victimization prior to entering DHS custody. [The Facility] shall provide postings in all housing units with the community resources mailing address and telephone numbers (including toll-free hotline numbers where available). The Facility shall maintain or attempt to enter into memoranda of understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime. The Facility shall enable reasonable communication between detainees and these organizations and agencies, in a confidential manner as possible. The Facility will inform detainees, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." As noted in 115.21, JPCC has a written MOU with WINN Community Health Center to provide victims of sexual assault emotional support, crisis intervention and information if needed. They also have an unsigned agreement with Project Celebration Inc., an accredited Sexual Assault Center, to provide advocacy service, crisis hotline, forensic support and legal interview support if needed. The Auditor spoke with a representative of both agencies, who validated their agencies would provide emotional support, crisis intervention and community referrals if requested. Both indicated their agency has not had any contact with detainees during the audit period. In each of the five thoroughly investigated files, the Auditor found notations that indicated detainees were informed of the victim advocate on the day of the allegation. The Auditor observed, during the facility tour, the contact information for both these advocates in all of the detainee living areas. Both agencies informed the Auditor that they do not accept allegations of sexual abuse. The JPCC facility Detainee Handbook and notices about these agencies informs detainees the extent that the calls to them may be monitored.

§115.54 - Third-party reporting.

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

Notes:

The Auditor determined compliance with the standard after review of policy 2.11 that states, "Jackson Parish Correctional Center shall post publicly, third-party reporting procedures on its public website to show its method receiving third-party reports of Sexual Abuse and Sexual Harassment." The Auditor observed third-party reporting information, in Spanish and English, throughout the facility, to include the entrance lobby. The JPCC website (https://lasallecorrections.com) and ICE website (https://www.ice.gov/detain/prea) include third-party reporting information as well. Most of the 20 detainees interviewed were aware that family members and friends could report sexual abuse on their behalf. The PSA Compliance Manager and Investigator confirmed there were no third-party allegations received during the audit period.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Jackson Parish Correctional Center shall require all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The Facility shall ensure that all staff are trained on appropriate reporting procedures, including a method by which staff can report outside the chain of command; staff members who become aware of alleged sexual abuse shall immediately follow reporting requirements set forth in JPCC's written policy and procedures; and apart from such reporting, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions." The 12 random staff interviews confirmed their knowledge of the policy and standard reporting requirements. They were also knowledgeable of their right to report allegations outside the chain of command (Corporate Headquarters) if necessary. They also confirmed that apart from reporting to the designated supervisor or officials, they are required not to reveal any information related to a sexual abuse report to anyone. Policy 2.11 was approved by the AFOD. Of the 14 allegations reported during the audit period, 13 were reported to LaSalle staff and 1 to ICE. The five investigative files thoroughly reviewed by the Auditor demonstrated staff immediately reported the incidents to their supervisors.

(d) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "When [the] alleged victim is under 18 or considered a vulnerable adult under a State or Local vulnerable person statute the FOD will be advised." There are no juveniles placed at JPCC. The Warden confirmed any vulnerable adult victim of sexual abuse would be immediately reported to the AFOD and the JPSO.

§115.62 - Protection duties.

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

Notes:

The Auditor determined compliance with the standard after review of policy 2.11 that requires, "All staff and detainees are responsible for being alert to signs of potential situations in which sexual assaults might occur, and if a facility staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." The interview protocols for the Warden and random staff specifically ask how each would respond to a situation where a detainee may be in substantial risk of sexual abuse. All informed the Auditor they would find the detainee and immediately place her in an area for protection. The PAQ and interviews with the Warden and PSA Compliance Manager confirmed JPCC had no detainees at substantial risk of imminent sexual abuse within the audit reporting period.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the agency or facility whose staff received the allegation shall notify the ICE Field Office and the administrator of the facility where the alleged abuse occurred. The notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. The Facility shall document that it has provided such notification. The Facility shall ensure all allegations are referred for investigation upon receiving such notification of sexual abuse from another confinement facility about a detainee who was previously detained at PDC and shall immediately notify the ICE Field Office Director." The Warden informed the Auditor if staff received a report of sexual abuse from a detainee on arrival at JPCC that occurred at another facility, he would notify the sending facility within 72 hours and immediately notify the AFOD. There were no allegations made at other facilities reported to have occurred at JPCC or any allegations made occurring at other facilities during the audit period.

§115.64 - Responder duties.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report shall be required to: Separate any detainee who alleges that he/she has been sexually assaulted from the alleged assailant; Immediately notify the Facility Administrator or on call supervisor and remain on the scene until relieved by responding personnel: In the event this occurred, the ICE AFOD or designee will be notified; Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse or sexual abuse occurred within a time period that still allows for the collection of physical evidence, do not let the alleged victim or abuser take any actions that could destroy physical evidence, including as appropriate, washing, brush teeth, changing clothes, urinating, defecating, smoking, drinking and eating. It is important that all contact with [the] alleged victim, be sensitive, supportive, and non-judgmental. Apart from reporting to designated supervisors, Employees shall not reveal any information related to the incident to anyone other than to staff involved with investigating the alleged incident." The random security staff (12) interviewed detailed their responsibilities when responding to any allegation of sexual abuse. Their responses reflected the requirements of subpart (a) and 2.11 policy. The five randomly selected sexual abuse allegations reviewed in detail by the Auditor appeared to confirm that the first responder followed the requirements of the standard and JPCC policy 2.11.

(b) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "If the first responder is not security staff, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." The Auditor interviewed two non-security staff and each confirmed if a sexual abuse incident was reported to them, they would secure the alleged victim, not allow her to destroy evidence, and immediately call for a security staff member. There were no allegations made to non-security staff during the audit period.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that states, "The Facility has developed a plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The plans shall coordinate actions of staff responders, which are Medical and Mental Health Practitioners, facility investigators, PREA Coordinator, Duty Warden and any other staff deemed necessary by the Facility Administrator. The Facility PREA Compliance Manager shall be [a] required participant and the Corporate PREA Coordinator shall be consulted as part of this coordinated response." The Warden and PSA Compliance Manager stated that the JPCC policy 2.11 is the facility's written plan that coordinates actions taken by staff in response to all incidents of sexual abuse at the facility. The 2.11 policy was approved by the AFOD. The Auditor thoroughly reviewed 5 of the 14 investigative files and found the administrative investigations documented the multidisciplinary and coordinated responses taken by staff members in response to the allegation of sexual abuse.

(c)(d) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "When a transfer of a detainee victim from an ICE facility to any facility, where permitted by law, [the facility shall] inform them of need for

medical or social services, unless [the] victim request[s] otherwise. If it's an unknown facility, then the FOD is notified so they can determine notification." The HSA confirmed that JPCC has had no detainee victim of sexual abuse transferred between a DHS or non-DHS detention facility within the audit period and that JPCC would notify the receiving facility of the need for medical or social services as permitted by law.

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

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

Notes:

The Auditor determined compliance with this standard after review of policy 2.11 that requires, "In the case where staff, contractors, and volunteers are suspected of perpetrating sexual abuse, they shall be removed from all duties requiring detainee contact pending the outcome of an investigation." The facility had two allegations of sexual abuse made against a staff member during the audit period. One of the allegations did not name or identify the staff member. The other staff member was removed from any contact with detainees until the conclusion of the investigation. The Auditor was provided a copy of the no contact letter.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "Staff, contractors, and volunteers, and detainees, shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." The interview with the Warden and PSA Compliance Manager confirmed JPCC prohibits any form of retaliation.

(b)(c) Policy 2.11 requires "For at least 90 days following a report of sexual abuse, the Chief of Security shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. The Chief of Security shall monitor any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. DHS shall continue to monitor beyond 90 days for retaliation whenever a continuing need." The interview with the PSA Compliance Manager confirmed that JPCC has a form to document retaliation but has not monitored for any retaliation of staff or detainee. The review of the investigative files had no retaliation monitoring documented.

Does Not Meet (b)(c): The facility must employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. To meet compliance, the facility shall document retaliation monitoring following every allegation of sexual abuse employing requirements of subpart (b) and policy 2.11 requirements. The Auditor will need to verify retaliation monitoring for staff, as well as detainees, with at least five examples of completed retaliation monitoring. Additionally, the facility shall provide refresher training to the employees designated as retaliation monitors of the requirements outlined in this standard and policy 2.11 and provide documentation of completion.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "The victim shall be housed in a supportive environment that represents the least restrictive housing option possible, and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. Detainee victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. The Facility shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours." The Warden confirmed the use of administrative segregation for any detainee victim of sexual abuse or based on their vulnerability to sexual abuse or assault would be highly unlikely at JPCC. He stated if segregation was ever used to protect a victim of sexual abuse, he would make the required 72-hour notification to the AFOD. He further stated that a classification and vulnerability assessment would be completed on the detainee prior to her being placed back in general population. As noted in 115.43, administrative segregation has not been used to house an alleged victim or vulnerable detainee. There were no detainees who alleged sexual abuse present at JPCC at the time of the on-site visit to interview.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b)(c)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Where sexual abuse is alleged, The Facility shall use investigators who are specially trained, qualified investigators in sexual abuse investigations and they must be prompt, thorough, objective and fair. Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The Administrative investigations includes:

preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings, and retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. The departure of the alleged abuser or victim from the employment or control of the Facility shall not provide a basis for terminating an investigation. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations to ensure that the latter is not compromised by the former, including the process for conducting internal administrative investigations only after consultation with the assigned criminal investigation entity or after a criminal investigation has concluded. The Warden shall ensure that the criminal investigation is not compromised by an internal administrative investigation."

The Facility Investigator stated that upon every allegation of sexual assault he notifies the JPSO and waits to conduct his administrative investigation after consultation with the appropriate investigative offices within DHS. He also stated that he cooperates with the outside agency conducting the criminal investigation and providing assistance as needed. He also confirmed during his interview that the administrative investigations are based on direct and circumstantial evidence; available physical DNA evidence; available electronic monitoring data; interview notes from alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator. He indicated he assesses the credibility of any alleged victim, suspect, or witness, based on evidence without regard to their status as a detainee, employee, or contractor and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph. There were 14 allegations reported during the audit period that were handled administratively and not determined criminal by the JPSO. The Auditor conducted a thorough review of five investigative files. The thorough review of the five administrative investigative files confirmed the investigation was conducted by the facility trained investigator. The Auditor believes all the element requirements of the policy and standard were followed and the investigations appeared prompt, thorough and objective. The 2.11 policy was approved by the AFOD.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with this standard after review of policy 2.11 that requires, "JPCC shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated." The interview with the facility's Investigator confirmed the standard used, when determining a sexual abuse investigation is substantiated, is the preponderance of evidence. In review of the five completed investigative files for the audit period, it appeared to the Auditor that a preponderance of the evidence was the standard used in determining the outcome of the investigation.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with this standard after review of policy 2.11 that requires, "Following an investigation into a detainee's allegation that he or she suffered sexual abuse in the facility, the Facility shall inform the detainees as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." The Auditor provided the Team Lead with the names of the detainee investigative files (5) that were thoroughly reviewed while on site. Four of the five cases demonstrated the detainee was provided the result of the investigation outcome. The one was unable to provide the date it was issued to the detainee.

§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) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "The Facility shall ensure that staff be subject to disciplinary or adverse actions, up to and including removal from their position and from the Federal service, when there is a substantiated allegation of sexual abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Termination shall be the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse." The 2.11 policy was approved by the AFOD. The interviews with the Warden and the HR Manager confirmed removal from their position at JPCC and from the Federal service is the presumptive disciplinary sanction for any staff member who has engaged in or attempted or threatened to engage in sexual abuse or failed to follow the zero-tolerance policy. JPCC had two allegations of sexual abuse made against staff. The Auditor's investigative file review found one allegation was made against an unnamed staff member and was determined unfounded, and the second was determined to be unsubstantiated at the conclusion of that investigation.

(c)(d) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies." The Warden confirmed he would be required to make these notifications if it ever became necessary. All allegations of sexual abuse are reported to the JPSO. The Warden and the JPCC PAQ indicated that the facility had no staff removed for violation of the 2.11 zero-tolerance policy.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Contractors and volunteers suspected of perpetrating sexual abuse shall be immediately removed from all duties requiring detainee contact pending the outcome of an investigation. The Facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors and volunteers who have not engaged in sexual abuse but have violated other provisions within these standards." JPCC has no contractors on site that are not under escort by security staff. Volunteers have not been at the facility for the last 2 years because of the pandemic. The Warden confirmed contractors and volunteers would face removal from the facility for any violation of the facility's zero-tolerance policy and confirmed that none were removed for violation of the facility's 2.11 zero-tolerance policy. The cursory investigative file review by the Auditor found no allegations made against any contractor or volunteer during the audit period.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Detainees shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the detainee engaged in detainee-on-detainee sexual abuse or following a criminal finding of guilt for detainee-on-detainee sexual abuse. Sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. JPCC's detainee disciplinary system operates with progressive levels of reviews, appeals, procedures, and documentation procedure. JPCC's disciplinary process shall consider whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. JPCC shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The Warden and the PSA Compliance Manager detailed the disciplinary process at JPCC to the Auditor. Both confirmed that prior to any disciplinary hearings, the mental competency of the abuser is evaluated and would be taken into consideration during the hearing. The Warden confirmed that all incidents involving staff that consented would not result in any discipline to the detainee. He also stated that the facility disciplinary process allows for progressive levels of reviews, appeals, procedures, and documents the procedures. Of the 14 allegations reported during the audit period, 12 allegations of sexual abuse made against another detainee. Eleven were unsubstantiated and one was unfounded; therefore, no disciplinary action was taken by the facility.

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

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "If during the intake screening assessment, Intake officers or Medical staff screening the detainees will be able to determine if a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow is initiated, the detainee shall receive a health evaluation no later than two working days from the date of the assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." Interviews with the intake officer confirmed that when staff learn a detainee was a victim of sexual abuse or was an abuser, he/she ensures that the detainee is immediately referred to a qualified medical or mental health practitioner for follow-up as appropriate. She indicated notifications are typically done by email, telephone call, or discussion with medical staff in the intake area at the time. The HSA confirmed when a medical follow-up is initiated, the detainee receives a health evaluation typically the same or next day, but no later than two working days from the date of the assessment. The interview with the mental health practitioner confirmed when a referral for mental health is initiated, the detainee receives a mental health evaluation no later than 72 hours after the referral. The Auditor interviewed two detainees who disclosed prior victimization during their risk assessment. Both indicated they were offered and received medical/mental health referral on the day they arrived. Their medical records were reviewed, and confirmed they were both seen on the day of their arrival.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "Detainee victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature, and scope of which are determined by medical and mental health practitioners according to their professional judgment. Detainee victims are provided emergency medical and mental health services and ongoing care as appropriate, including testing for sexually transmitted diseases and infections, prophylactic treatment, emergency contraception, following-up examinations for sexually transmitted diseases, and referrals for counseling (including crisis intervention counseling). Detainee victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted

infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Emergency medical treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." JPCC had 14 allegations of sexual abuse during the audit period. There were none of these 14 detainees at the facility at the time of the on-site visit to interview. The Auditor reviewed the medical record of five of these detainees and their investigative files. According to the records reviewed, the detainees were seen by medical/mental health the same day as the allegation was reported. The HSA confirmed detainee victims of sexual abuse receive medical care and crisis intervention as stipulated in subparts (a)(b) and indicated all services are provided without cost to the victim. As stated in standard 115.21, all forensic exams and emergency treatment services are provided at the outside hospital (Jackson Parish Hospital); the facility would only triage the detainee prior to transport. JPCC has a MOU with the Jackson Parish Hospital that agrees to provide a SAFE or SANE, when needed. If SAFEs or SANEs cannot be made available, the examination would be performed by other qualified medical practitioner at the Jackson Parish Hospital. She also indicated two forensic examinations were performed at this outside hospital during the audit period with negative findings.

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

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. Evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. The Facility shall provide such victims with medical and mental health services consistent with the community level of care. Emergency medical treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Detainee victims are provided emergency medical and mental health services and ongoing care as appropriate, including testing for sexually transmitted diseases and infections, prophylactic treatment, emergency contraception, following-up examinations for sexually transmitted diseases, and referrals for counseling (including crisis intervention counseling)." The HSA confirmed any detainee who experiences sexual abuse while in detention would receive medical and mental health services and treatment consistent with the community-level of care without cost to the detainee, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. She also stated her medical department would provide pregnancy and sexually transmitted disease testing and provide medications where appropriate. JPCC had 14 allegations of sexual abuse reported during the audit period. None of those detainees were present at the facility at the time of the site visit. The Auditor reviewed five medical records from the 14 and their associated investigative files. According to the records reviewed the detainee was seen by medical/mental health the same day as the allegation was reported.

§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) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "The Facility Administrator will ensure staff conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The Warden shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the Field Office Director, for transmission to the ICE PSA Coordinator. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility." The Auditor interviewed a member of the Incident Review Team, who indicated an incident review is conducted on every allegation of sexual abuse with the review documented in writing regardless of the outcome. The Auditor thoroughly reviewed five investigative files for the audit period. In each file was a written incident review conducted within 30 days of the investigation conclusion.

(c) The Auditor determined compliance with these subparts of the standard after review of policy 2.11 that requires, "The Warden shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and Field Office Director or his or her designee, who shall transmit it to the ICE PSA Coordinator." The Auditor was provided the 2021 annual review as required by subpart (c), with documentation to support a copy was sent to the ICE PSA Coordinator and the FOD.

§115.87 - Data collection.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard after review of policy 2.11 that requires, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling, shall be maintained in the

PREA Program Manager's office in a locked file cabinet, consistent with the confidentiality requirements of the Detention Standards on "Medical Care" and "Detention Files." The Auditor observed the case record storage, and confirmed these documents are kept under double lock and restricted key.

§115.201 - Scope of audits.

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

Notes:

(d) The Auditor was allowed access to the entire facility and able to interview staff and detainees about sexual safety during the site visit.
(e) The Auditor was able to revisit areas of the facility and to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j) Audit notices were posted and observed throughout the facility in English and Spanish. The Auditor received no staff or detainee correspondence.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	31
Number of standards not met:	6
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 3/17/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 3/17/2022

PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 3/17/2022

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:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-(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:	New Orleans Field Office		
Field Office Director:	(b) (6), (b) (7)(C) (Acting)		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1250 Poydras Suite 325 New Orleans, LA 70113		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Jackson Parish Correctional Center (JPCC)		
Physical address:	327 Industrial Drive Jonesboro, LA 71251		
Mailing address: *(if different from above)*	287 Industrial Drive Jonesboro, LA 71251		
Telephone number:	318-259-4309		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	Phil Bickham	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	229-402-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	318-259-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Jackson Parish Correctional Center (JPCC) was conducted on January 25-27, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Custom Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The audit period is March 9, 2021, through January 21, 2022The JPCC is privately owned by LaSalle Corrections and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the JPCC are from Haiti, Nicaragua, and Venezuela. The facility does not house juveniles, males, or family detainees. This was the first PREA audit for the facility located in Jonesboro, Louisiana.

During the audit, the Auditor found JPCC met 31 standards, had 2 standards (115.31 and 115.35) that exceeded, had 2 standards (115.14, 115.18) that were non-applicable, and 6 non-compliant standards (115.17, 115.22, 115.41, 115.43, 115.52 and 115.67). As a result of the facility being out of compliance with 6 standards, the facility entered into a 180-day corrective action period which began on March 18, 2022, and ended on September 14, 2022. The purpose of the of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

The Auditor received notification of the first CAP via email on April 26, 2022, from ERAU. The CAP was reviewed and approved by the auditor for the six standards that did not meet compliance during the PREA audit site visit and documentation review. The Auditor received CAP documents in May 2022 and received the final CAP documents for review in August 2022 that were provided by the facility to demonstrate compliance with these standards. This documentation was reviewed, and the Auditor determined that the facility demonstrated compliance with each of the six standards found non-compliant at the time of the site visit.

Number of Standards Met: 6

§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.41 Assessment for risk of victimization and abusiveness
§115.43 Protective custody
§115.52 Grievances
§115.67 Agency protection against retaliation

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.

§115.17 - Hiring and promotion decisions

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

Notes:

(b) Policy 2.11 requires, "The Facility when considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The facility, consistent with law, shall make its best effort to contact all prior institutional employers of any applicant for employment, to obtain information of substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. The Facility shall also impose upon employees a continuing affirmative duty to disclose any such conduct." The Auditor reviewed 10 randomly chosen employee files. Five of them were recently promoted and the Auditor observed signed affirmations that the staff member had not been involved in misconduct outlined in subpart (a). The HR staff person stated the facility, along with ICE, would request information from prior institutions where the prospective candidate was previously employed during background checks. The HR staff person also stated that as a condition of employment, each employee has a continuing affirmative duty to disclose to either her office or their supervisor any behavior outlined in subpart (a). The Auditor interviewed 12 random staff, and each was aware of this affirmative duty to report. However, the random staff interviewed indicated that they are not asked to acknowledge in writing at evaluation time that they have not been involved in behavior outlined in subpart (a) and there was no documentation to support that there is a process in place

Does Not Meet (b): The review of the employee files and the interview with the JPCC Human Resources (HR) staff person confirmed the facility is not complying with the policy or standard requirement that in written self-evaluations, conducted as part of reviews of current employees, each staff member must submit confirmation that he/she has not been involved in misconduct as outlined in subpart (a). The facility must demonstrate compliance by providing documentation for 10 random staff after implementation.

Corrective Action Taken (b): On April 13, 2022, JPCC submitted a CAP stating it had conducted a self-evaluation for each employee confirming that he/she had not been involved in any misconduct as stated in policy. They also indicated they would be conducting the required evaluation annually for all staff members. JPCC also indicated they would be providing 10 examples of staff members completing this subpart (b) annual evaluation as required in the CAP. On May 6, 2022, the facility provided examples for 10 employees who have attested to the misconduct questions using the DHS ICE form pertaining to 6 CFR Part 115.117(a). The Auditor reviewed these documents and determined that the facility has demonstrated compliance with this 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:

(e)(f) Policy 2.11 requires, "If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reporting to the Field Office Director." Additionally, when a detainee(s) is alleged to be the perpetrator, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to the Field Office Director. All perpetrators of sexual abuse or assault shall be disciplined and referred for criminal prosecution as appropriate. The interview with the Warden and PSA Compliance Manager confirmed that JPCC notifies the SDDO on every allegation. The interview with the SDDO also confirmed that whenever an allegation of sexual abuse is made at JPCC he is notified as required and is responsible to make the notifications to these ICE personnel as required by this subpart. Of the five randomly selected investigative files chosen for thorough review, the Auditor found documentation that ICE was notified in each of the incidents; however, there was no indication that the JIC was notified as required by this subpart. The interview with the SDDO confirmed that he is informed of all allegations of sexual abuse. He also stated that he is required to make all the notifications to ICE personnel. Based on the JPCC PREA Allegations spreadsheet, only 1 of the 14 allegations was reported to the Joint Intake Center (JIC). The facility made notification to ERO, but ERO did not make the JIC notification

Does Not Meet (e)(f): A review of the JPCC PREA Allegations spreadsheet indicated that the JIC was notified of only 1 of 14 allegations. The interview with the SDDO confirmed that once he is notified of an allegation of sexual abuse, he is

responsible for making the other notifications. The standard requires that incidents of sexual abuse be promptly reported to the JIC, the ICE OPR/DHS OIG, and the appropriate ICE FOD.

Corrective Action (e)(f): On May 6, 2022, JPCC submitted a CAP stating that once ERO receives notification of an allegation the SDDO on duty assigned to the New Orleans (NOL) area of responsibility will make the proper notifications and complete the SIR. An email box is in place which is distributed to all supervisors within the local area who are on duty. Notifications may be received telephonically and followed up with an email to memorialize the allegation. The Auditor did not concur with the initial CAP response as it did not indicate how SAAPI allegation notifications to JIC are made for allegations occurring at JPCC. The SDDO informed the Auditor during the site visit that he makes all notifications of SAAPI incidents to the JIC but the excel spreadsheet indicated in 13 instances JIC was not notified. The Auditor requested ICE submit documentation identifying the staff responsible for making JPCC SAAPI allegation notifications to the JIC and submit documentation for five allegation notifications which may occur during the CAP. The Auditor reviewed the memorandum from the OIC to all ERO staff assigned to the JPCC regarding 'Proper Reporting of Sexual Abuse Allegations.' This document directs staff to promptly report incidents of sexual abuse to the JIC, ICE OPR/DHS OIG, and the NOL FOD in accordance with policy and through their chain of command. Additionally, the facility advised that there have been no reported allegations during the CAP period. The Auditor accepts this action as demonstration of compliance with 115.22.

§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) Policy 2.11 requires, "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." The interview with the HSA confirmed that the medical staff perform the second reassessment and any special assessments beyond the initial performed upon arrival. She also confirmed the vulnerability reassessment is completed prior to the 30th day after the initial assessment. The Auditor reviewed five medical files and found reassessments completed around day 30 of the detainee being at JPCC, instead of within 60–90 days of the initial reassessment. In addition, the facility was unable to provide documentation that a risk assessment was performed on any of the five detainees alleging sexual abuse whose investigative files were reviewed by the Auditor.

Does Not Meet (e): The Auditor's review of five medical files discovered reassessments are completed around day 30 of the detainee being at JPCC. The form that JPCC uses for the reassessment states 30-day reassessment instead of the 60–90-day reassessment the standard and policy require. Furthermore, there was no risk assessment performed on detainees alleging sexual abuse as required by subpart (e). The facility needs to follow both the DHS PREA standard and their 60–90-day policy requirement. To meet compliance, the facility needs to perform a reassessment on all detainee victims and alleged abusers as required by Policy 2.11 and the standard after an incident of sexual abuse; provide the Auditor at least one completed assessment performed on an alleged abuser and victim after the initial audit period; and provide the Auditor with 10 (60-90) reassessments completed after implementation of the updated procedures.

Corrective Action Taken (e): On April 13, 2022, JPCC submitted a CAP stating JPCC had changed the PREA Screening form of 30-day reassessment to 60–90-day reassessment to align with requirements of the policy and standard. JPCC completed 2 additional 60–90-day reassessment and provided to the Auditor for compliance review. The Auditor requested 4 additional 60–90-day reassessments and requested the JPCC address the deficiency where the facility failed to conduct reassessments on detainee victims and abusers involved in sexual abuse allegations. On September 13, 2022, the Auditor reviewed six 60–90-day reassessments JPCC completed; however there were no allegations reported within the CAP period for the facility to provide additional reassessments post allegation. The facility advised they will continue to meet the requirements to assess any detainee (alleged abuser and victim) that has had an incident of abuse or victimization. The Auditor accepts this information as demonstration that the facility is now fully compliant with standard 115.41.

§115.43 - Protective custody

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

Notes:

(d) This subpart requires written procedures directing a supervisory staff member conduct a review within 72 hours of a detainee's placement in segregation to determine whether segregation is still warranted, and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in Administrative Segregation and every week thereafter for the first 30 days and every 10 days thereafter. The policy 2.11 only requires, "every 30 days, the facility shall afford each such a review to determine whether there is a continuing need for separation from the general population."

Does Not Meet (d): The facility needs to update their written procedures, 2.11 policy, to reflect the subpart (d) requirements directing a supervisory staff member to conduct a review within 72 hours of a detainee's placement in segregation to determine whether segregation is still warranted and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in Administrative Segregation and every week thereafter for the first 30 days and every 10 days thereafter. Once the procedures have been revised, supervisory staff shall be trained on the new policy and documentation should be provided to the Auditor for compliance review.

Corrective Action Taken (d): The CAP documentation provided to the Auditor on May 2, 2022, indicated JPCC had updated the 2.11 policy to reflect the subpart (d) requirements of 115.43. The facility also provided the Auditor with the training roster containing 37 staff signatures of those attending this policy update. The facility is now compliant with the standard.

§115.52 - Grievances

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

Notes:

(e) This subpart requires the facility issue a decision on the grievance within 5 days of receipt and respond to an appeal within 30 days. Policy 2.11 states, "A Final decision shall be issued on the merits of any portion of the grievance alleging Sexual Abuse within 90 days of the initial filing of the grievance." The Grievance Officer confirmed the 90 days of the initial filing. This subpart also requires the AFOD be notified of the grievance and the decision. The policy does not address this notification and the Grievance Officer was uncertain of how he is notified.

Does Not Meet (e): The facility must update their policy to conform to the subpart requirement of the facility issuing a decision on the grievance within 5 days of receipt and responding to an appeal within 30 days. The policy also must address the AFOD notification of the grievance and the decision. The Auditor will need to review the updated policy and documented training of the Grievance Officer with the new policy requirements for compliance determination.

Corrective Action Taken (e): The May 5, 2022, CAP documentation provided to the Auditor included the updated policy 2.11, which included the addition of subpart (e) requirements. The facility also provided a Record of Training signed by the instructor and the grievance coordinator indicating that training was received on the revised Grievance System on April 4, 2022. The facility has demonstrated compliance with this standard.

§115.67 - Agency protection against retaliation

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

Notes:

(b)(c) Policy 2.11 requires "For at least 90 days following a report of sexual abuse, the Chief of Security shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. The Chief of Security shall monitor any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. DHS shall continue to monitor beyond 90 days for retaliation whenever a continuing need." The interview with the PSA Compliance Manager confirmed that JPCC has a form to document retaliation but has not monitored for any retaliation of staff or detainee. The review of the investigative files had no retaliation monitoring documented.

Does Not Meet (b)(c): The facility must employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. To meet compliance, the facility shall document retaliation monitoring following every allegation of sexual abuse employing requirements of subpart (b) and policy 2.11 requirements. The Auditor will need to verify retaliation monitoring for staff, as well as detainees, with at least five examples of completed retaliation monitoring. Additionally, the facility shall provide refresher training to the employees designated as retaliation monitors of the requirements outlined in this standard and policy 2.11 and provide documentation of completion.

Corrective Action Taken (b)(c): The May 5, 2022, CAP documentation provided to the Auditor included documentation of staff receiving training on retaliation monitoring to include the subpart (b)(c) requirement. The facility had no allegations to demonstrate compliance at this time and the Auditor requested they wait additional time during the CAP to see if the facility could demonstrate compliance of monitoring. During the review of documentation on September 13, 2022, the facility advised the Auditor they had no allegations during the CAP period. The facility advised they will meet the standard requirements to monitor any detainee or staff with any allegation of sexual abuse. The Auditor accepts this information as demonstration that the facility is now fully compliant with the standard.

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

Thomas Eisenschmidt September 15, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) September 26, 2022
Assistant Program Manager's Signature & Date

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