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

Homeland Security

AUDITOR INFORMATION			
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FIELD OFFICE INFORMATION			
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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Kay County Detention Center (KCDC)		
Physical address:	1100 W. Dry Rd, Newkirk Ok, 74601		
Mailing address: *(if different from above)*			
Telephone number:	580-362-3393		
Facility type:	IGSA		
Facility Leadership			
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Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	CIT/PREA Coordinator
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FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found KCDC met 25 standards, had 1 standard (115.31) that exceeded, had 2 standards (115.14, 115.18) that were non-applicable, and 13 non-compliant standards (115.16, 115.17, 115.21, 115.33, 115.41, 115.42, 115.43, 115.51, 115.67, 115.71, 115.76, 115.81, 115.86). As a result of the facility being out of compliance with 13 standards, the facility entered into a 180-day corrective action period which began on June 15, 2022, and ended on December 12, 2022. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

On July 7, 2022, the Auditor received notification of the facility's first CAP via email from the Office of Professional Responsibility's, External Reviews and Analysis Unit (ERAU) and reviewed the submission over the course of several days. Additional documentation and response were provided by the facility and reviewed by the Auditor on November 19, 2022, and December 27, 2022. At the conclusion of the CAP period, the Auditor determined that the facility demonstrated compliance with 12 of the 13 standards found non-compliant at the time of the site visit.

Number of Standards Met: 12

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

§115.17 Hiring and promotion decisions

§115.21 Evidence protocols and forensic medical examinations

§115.33 Detainee education

§115.41 Assessment for risk of victimization and abusiveness

§115.42 Use of assessment information

§115.43 Protective custody

§115.51 Detainee reporting

§115.67 Agency protection against retaliation

§115.71 Criminal and Administrative Investigations

§115.76 Disciplinary sanctions for staff

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

Number of Standards not Met: 1

§115.86 Sexual abuse incident reviews

PROVISIONS

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

§115. 16 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c) The policy 3-19 requires, "KCDC will ensure that inmates with disabilities (including, for example, inmates 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 KCDC's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps will include: Providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. That written materials are provided in formats or through methods that ensure effective communication with inmates with disabilities, including inmates who have intellectual disabilities, limited reading skills, or who are blind or have low vision. The PREA Officer will ensure that disabled inmates have access to these materials and programs. KCDC is not required to take actions that it can demonstrate or 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 Americans with Disabilities Act, 28 CFR 35.164. In matters relating to allegations of sexual abuse, each facility shall employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. Each facility shall provide detainees with disabilities and detainees with Limited English Proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." The intake process for detainees was detailed to the Auditor by two KCDC intake staff. According to them, each detainee arriving at KCDC receives the ICE National Detainee handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the Kay County Detention Center Handbook, all only available in English and Spanish at KCDC. The facility also provides detainees speaking Spanish and English with two informational videos (PREA and Know Your Rights) that run continuously in the intake area and in each housing unit. The Auditor was also informed by the two intake staff that when the facility is confronted with a detainee who may be hearing impaired or deaf, the required orientation information is either provided to the detainee in writing or through use of the facility text telephone (TTY). If staff is confronted with a detainee who is blind or has limited sight, he would be provided individualized service by a staff member, to include having the information read to him. The Auditor was also informed that if staff encounters any detainee with an intellectual disability, the staff will try to communicate with them to the best of their abilities. If they encounter any difficulty, then the detainee would be referred to a supervisor, medical staff, or mental health staff based on the detainee's limitation. The Auditor questioned intake staff about how they provide information to a detainee not covered by a language provided by the ICE National Detainee Handbook. They indicated they would utilize their contracted language service. However, they could not demonstrate what information is provided to a LEP detainee not covered by one of these languages. During the site visit, the Auditor was informed by intake staff and supervisors that the ICE National Detainee Handbook and the DHS-prescribed SAA pamphlets were only available only in English and Spanish. KCDC staff was informed by the Auditor that both these resources were available by the Agency in 14 languages and 9 languages, respectively. The PSA Compliance Manager stated to the Auditor that he had finished a manuscript of information to be provided to LEP detainees whose language is not covered by languages provided by the ICE National Detainee Handbook; however, the Auditor did not review the final edition of this manuscript since it was not completed in sufficient time for full implementation and compliance consideration within the audit period. The Auditor reviewed the four sexual abuse allegations and found none of the allegations involved a LEP detainee; therefore, compliance with provision (c) of the standard could not be ascertained through file review. The Auditor interviewed 20 randomly selected detainees. Even though some non-English and Spanish speaking detainees were chosen for interview, during their interview it was determined they understood one of these languages and understood the orientation materials provided. The detainee detention file (10) review documented by signature that the detainees had received the orientation materials.

Does Not Meet (b): The facility was not compliant with subsection (b) of the standard as it could not demonstrate it provided detainees who are LEP with language assistance, including through bilingual staff or professional interpretation and translation services, to ensure meaningful access to its programs and activities. To become compliant, the facility was

required to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainee who are LEP. The facility was required to provide five samples of intake information provided to detainees speaking a language not covered by the 14 languages covered by the ICE National Detainee Handbook. The PSA Compliance Manager had completed a manuscript that outlines the facility's efforts to prevent, detect, and respond to sexual abuse. The facility was required to provide evidence of the new process implementation that was developed by the PSA Compliance Manager at the time of the audit, and evidence that the process is being complied with; documentation of the interpretation service used to deliver the manuscript and signature of detainee's participation for the detainee who speak languages other than English and Spanish and must include detainees who speak a language other than one of the 14 languages covered by the ICE National Detainee Handbook.

Corrective Action (b): The Auditor reviewed the facility's initial response to the CAP on July 11, 2022, at which time the provided orientation manuscript was approved. The Auditor requested five examples of the SAAPI information being delivered using the manuscript with the assistance of an interpreter for detainees who speak languages not covered by the ICE National Detainee Handbook. On December 27, 2022, the Auditor reviewed two completed intake packages as demonstration of the SAAPI information being provided with the use of an interpreter. Based on the facility's explanation that they have only completed two qualifying intakes during the CAP period, the Auditor accepted these two samples and waves the requirement of five examples. The facility has demonstrated compliance with this standard.

§115. 17 - Hiring and promotion decisions

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

Notes:

(a)(b)(e)(f) The Auditor reviewed policy 3-19, Executive Order (EO) 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive, all of which detail suitability requirements for candidate hirings. KCDC policy 3-19 states, "KCDC will not hire or promote anyone who may have contact with inmates, and will not enlist the services of any contractor, who may have contact with inmates, who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. § 1997); Has been convicted of engaging or attempting to engage in sexual activity 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 has been civilly or administratively adjudicated to have engaged in the activity described above. KCDC will also ask all applicants and employees who may have contact with inmates directly about previous misconduct described above 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. KCDC will also impose upon employees a continuing affirmative duty to disclose any such misconduct. Material omissions regarding such misconduct, or the provision of materially false information, will be grounds for termination. Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Unless prohibited by law, KCDC will 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 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 KCDC Administrative Assistant confirmed potential employees are questioned specifically about any misconduct outlined in subpart (a) of this standard. An affirmative response to those questions would automatically disqualify the individual from hiring. She stated the facility would request information from prior institutions where the prospective candidate was previously employed, and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire. She also confirmed 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. The Auditor reviewed 10 employee files and found that KCDC does not require employees on an annual basis during their evaluations to ensure that they have not engaged in any activity prohibited by policy or by subpart (a).

Does Not Meet (b): The review of the employee files and the interview with the KCDC Executive Assistant confirmed the facility was not complying with this standard subpart requirement that during 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) of the standard. The facility was required to demonstrate compliance by providing documentation for 10 random staff after implementation.

Corrective Action (b): The Auditor reviewed the facility's initial response to the CAP on July 11, 2022, at which time the self-declaration document provided by the facility was approved. The Auditor accepted the CAP as written and requested the facility provide 10 examples of completed documents of staff during written self-evaluations. On December 27, 2022, the Auditor reviewed the 10 examples of the self-declaration form provided by the facility which included promotions, new hires, and existing employees as required. The standard is now compliant.

§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:

(b)(d) Policy 3-19 that states, "Each 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 victims' needs. Each facility administrator shall establish procedures to make available, to the full extent possible, outside victim services following incidents of sexual abuse. As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member will accompany and support the victim through the forensic medical examination process and investigatory interviews and will provide emotional support, crisis intervention, information, and referrals." The Auditor was provided and reviewed a Memorandum of Understanding (MOU) between the Survivor Resource Network (SRN) and KCDC, dated 3/4/2022 with no sunset date. An interview was conducted with a staff member from the SRN. This advocate confirmed her agency provides short-term crisis intervention to victims and survivors of sexual assault, rape, and molestation. KCDC was provided a 24-hour crisis hotline and mailing address for confidential contact with this advocate. The MOU between KCDC and states SRN shall, "Provide inmates with multiple internal ways to privately report sexual abuse and sexual harassment at no cost; Provide follow-up services and crisis intervention contacts to victims of sexual assault at KCDC; Respond to requests from KCDC to provide advocacy when inmates receive a sexual assault forensic exam or medical evaluation from the Sexual Assault Nurse Examiner; Act as a third party reporting agency by responding to calls from KCDC inmates received on the PREA hotline and report those calls to the KCDC administrators; and Respond to requests to provide a medical examination when inmates are in need of a sexual assault forensic exam." The facility Investigator confirmed that when the detainee is first taken to medical, they are provided victim advocate information by either the Investigator, PSA Compliance Manager, and/or medical staff after every report of an allegation. However, the Auditor's review of the documentation associated with the four closed allegations supported that only two alleged victims were offered victim advocacy services.

Does Not Meet (b): The facility reported four sexual abuse investigations during the audit period. In review of those four closed allegations, only two cases had case files and the other two allegations had an investigative summary prepared by the trained investigator. Within the two case files reviewed, the Auditor determined the alleged victims were offered victim advocacy services; however, the Auditor was not able to determine advocate services were provided as required by these subparts in the other two cases. The facility was required to demonstrate that advocate services are offered to each victim of sexual abuse as required by policy and standard.

Corrective Action (b): The Auditor accepted the initial CAP as written on July 11, 2022, which included a form (Attachment 115.21) to assist in documentation of advocate services being offered. The Auditor requested the facility provide three examples of the advocate services being offered to detainees alleging sexual abuse. The facility advised they had no allegations of sexual assault made during the CAP period; therefore, there was no opportunity to utilize the form. The Auditor accepted the implementation of the new form (Attachment 115.21) as demonstration of compliance.

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

(a)(b)(c)(e)(f) Policy 3-19 requires, "During the intake process, inmates will receive information explaining the KCDC's zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. This information is communicated orally and in writing in a language clearly understood by the inmate, prior to assignment to a housing unit. 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. Each facility's sexual abuse or assault prevention and intervention program shall provide detainees who are victims of sexual abuse or assault the option to report the incident or situation to a designated staff member other than an immediate point-of-contact line officer (e.g., the program coordinator or a mental health specialist). The facility shall provide detainees with the name of the program coordinator or designated staff member and information

on how to contact him or her. Detainees will also be informed that they can report any incident or situation regarding sexual abuse, assault, or intimidation to any staff member (as outlined above), the DHS Office of Inspector General, and the Joint Intake Center. Methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of contact line officer, the Detention and Reporting Information Line (DRIL), the DHS/OIG and the ICE/OPR investigation processes. The facility shall maintain documentation of detainee participation in the instruction session."

The Auditor's review of the orientation program found that it includes all elements required (1-6) of this standard; however, as noted in 115.16, detainees arriving at KCDC are only provided an ICE National Detainee Handbook, the Kay County Detention Center handbook, the DHS-prescribed SAAPI pamphlet, and are shown a PREA video (PREA and Know Your Rights), all in English or Spanish only. The intake process for detainees was detailed to the Auditor by two KCDC intake staff. Detainees arriving at KCDC receive these resources in these languages only. The Auditor was also informed by these two intake staff that when the facility is confronted with a detainee who may be hearing impaired or deaf, the required orientation information is provided to them in writing or through use of the facility TTY. If staff is confronted with a detainee who is blind or has limited sight, he would be provided individualized service by a staff member to have the information read to him. The Auditor was also informed that if staff encounters any detainee with an intellectual deficiency, the staff will try to communicate to them to the best of their abilities. If they encounter any difficulty, then the detainee would be referred to a supervisor, medical staff, or mental health staff based on the detainee's limitation. The Auditor questioned the intake staff about detainees not speaking one of the languages not represented by the ICE National Detainee Handbook that they have. They indicated they would utilize their contracted language service to provide this information. However, they could not demonstrate what information they provide a LEP detainee not covered by one of these languages. During the site visit, the Auditor was informed by intake staff and supervisors that the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet were available only in English and Spanish at the facility. However, ICE National Detainee Handbook is available in 14 languages (English, Spanish, Punjabi, Russian, Arabic, Chinese, French, Haitian Creole, Portuguese, Hindi, Romanian, Turkish, Bengali, and Vietnamese) and the DHS-prescribed SAAPI pamphlet is available in 9 languages (English, Spanish, Arabic, Chinese, French, Haitian Creole, Hindi, Portuguese, and Punjabi). KCDC staff was informed by the Auditor that both these resources were available by the Agency through ERO in PDF format for printing as needed and distribution to detainees. The PSA Compliance Manager stated to the Auditor that he had finished a manuscript of information to be provided to LEP detainees whose language is not covered by one of the Handbook languages. The Auditor interviewed 20 randomly selected detainees. Even though some non-English and Spanish speaking detainees were chosen to interview, during their interview, it was determined they understood one of these languages (Spanish or English); and therefore, understood the orientation materials provided. The review of the detainee detention files (10) demonstrated by detainee signature that each of the detainees had received the required orientation materials. The Auditor observed the DHS prescribed SAA Information pamphlet in Spanish and English was posted in each of the living areas.

Does Not Meet (b)(c): The facility could not demonstrate it provides detainees, speaking a language not covered by the ICE National Detainee Handbook, an orientation program that informs them about the agency's and facility's zero tolerance policies for all forms of sexual assault, to include the six subpart (a) requirements. The PSA Compliance Manager had completed a manuscript that outlines the facility's efforts to prevent, detect, and respond to sexual abuse addressing the subpart (a) requirements. The facility was required to provide evidence of the new orientation process implementation developed by the PSA Compliance Manager at the time of the audit. The facility was also required to document, by detainee signature, the interpretation service used to deliver the new manuscript to five detainees who speak languages other than one of the 14 languages covered by the ICE National Detainee Handbook.

Corrective Action (b)(c): The Auditor reviewed the facility's initial response to the CAP on July 11, 2022, at which time the provided orientation manuscript was approved. The Auditor requested five examples of the SAAPI information being delivered using the manuscript with the assistance of an interpreter for detainees who speak languages not covered by the ICE National Detainee Handbook. On December 27, 2022, the Auditor reviewed two completed intake packages as demonstration of the SAAPI information being provided with the use of an interpreter. Based on the facility's explanation that they have only completed two qualifying intakes during the CAP period, the Auditor accepted these two samples and waves the requirement of five examples. The facility has demonstrated compliance with this standard.

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

(a)(b)(c)(d) Policy 3-19 requires, "the facility shall assess all detainees on 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. The facility 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. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: 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 policy further states, "Intake screening will take place within 24 hours of arrival at the facility." The PSA Compliance Manager realized that the risk assessment document that was being utilized by the intake staff at the time of the site visit was not the correct document. The document they were using did not address four of the 10 requirements of subparts (c)(d). It is clear that the facility is assessing all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims to satisfy subpart (a); however, the form they have been using does not include four of the required elements for consideration. The review of the 10 detention files found this incorrect document as well. During the site visit, the PSA Compliance Manager had the intake staff end the use of this document and utilize the correct facility assessment document. The 3-19 policy will need to correct the requirement that the assessment be completed within 12 hours instead of the noted 24 hours. The interview with the Classification Officer indicated the classification and housing process is completed within 12 hours of the arrival. The interviews with the random detainees confirmed their classification was completed within their first two hours of arrival at KCDC.

Does Not Meet (c)(d): The risk assessment document the facility was using did not address 4 of the 10 requirements of subparts (c)(d). During the site visit, the PSA Compliance Manager had the intake staff end the use of this document and utilize the correct facility assessment document; however, KCDC was required to provide six examples of the facility utilizing the correct form during the CAP period for the Auditor's review to ensure this process is fully implemented.

Corrective Action (c)(d): The Auditor reviewed the initial CAP on July 11, 2022, which included a copy of the new risk assessment document for use on initial intake. The new form addresses the subpart (c)(d) elements. The Auditor requested 6 examples of this form being utilized. On November 16, 2022, the facility provided 6 examples of initial assessments completed using the new form which were reviewed by the Auditor. The facility has demonstrated compliance with (c) and (d) of this standard.

(e) Policy 3-19 requires, "The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the 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 PSA Compliance Manager confirmed KCDC conducts reassessments on all detainees at the facility between the 60-90-day requirement. The Auditor interviewed 20 random detainees. Seven of these detainees were eligible for this reassessment but indicated during their interview that they did not receive one. The review of their detention files did not demonstrate this reassessment was completed. The four investigative files were reviewed and none of the detainees received a reassessment as a result of the allegation of sexual abuse as required under this subpart.

Does Not Meet (e): The Auditor's review of the four detainee files alleging sexual abuse found no risk assessments completed after report of the allegation. Furthermore, during interview, seven detainees who were eligible for a 60-90-day reassessment indicated they had not received one; the Auditor's review of their related detention files further confirmed there was no reassessment completed. The facility needs to follow both the DHS PREA standard and their 60–90-day reassessment policy requirement. To meet compliance, the facility must perform a reassessment on all detainee victims and alleged abusers as required by policy 3-19 and the standard after an incident of sexual abuse; provide the Auditor at least one completed assessment performed on an alleged abuser and victim; and provide the Auditor with 10 (60-90-day) reassessments completed after implementation of the updated procedures.

Corrective Action (e): On July 11, 2022, the Auditor reviewed the initial CAP response provided by the that outlined their proposed procedures to ensure reassessments, both 60-90 day and post-incident of sexual abuse, are conducted. The Auditor approved the CAP as proposed and requested 10 examples of the 60–90-day assessment being utilized, and 3 examples of a risk assessment being completed on detainees alleging sexual abuse. On November 16, 2022, the facility provided 10 examples of the 60–90-day assessment using the updated forms. The facility also informed the Auditor that KCDC had no allegations of sexual abuse reported during the CAP period; therefore, no examples to provide of a reassessment after an incident. The facility has demonstrated compliance with provision (e) of this standard.

§115. 42 - Use of assessment information

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

(a) Policy 3-19 requires, "KCDC will use information from the risk screening form to notify housing, bed, work, education, and program assignments. KCDC will attempt to keep separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. KCDC will make individualized determinations about how to ensure the safety of each inmate." As noted in standard 115.41, the risk assessment was not acquiring all the information required in the (c)(d) subparts. Therefore, the facility is not able to make individualized determinations from all information required by the risk assessment.

Does Not Meet (a): The PSA Compliance Manager realized an incorrect form was being used during the site visit and placed the correct form in the intake area. The facility was required to provide six examples of the facility utilizing the correct form for each detainee's individualized determinations for compliance review.

Corrective Action (a): On July 11, the Auditor reviewed and approved the initial CAP provided by the facility on, pending review of the six examples of the facility utilizing the correct form. On November 16, 2022, the facility provided the six examples as requested. The facility is compliant with this standard subpart.

(b)(c) Policy 3-19 states, "In deciding whether to assign a transgender or intersex inmate to housing and programming assignments, classification will consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems. A transgender or intersex inmate's own view with respect to his or her own safety will be given serious consideration. Placement and programming assignments for each transgender or intersex inmate will be reassessed by the Classification Officer at least twice each year to review any threats to safety experienced by the inmate. The Classification Officer will document the reviews. Transgender and intersex inmates will be given the opportunity to shower separately from other inmates." The interviews with the PSA Compliance Manager and Classification Officer confirmed that KCDC has not had a transgender or intersex detainee at the facility over the past three years. They both indicated that should they receive a transgender or intersex detainee, they would follow policy. Although this standard does not require a policy, both indicated they would follow policy 3-19, which does not have procedures governing that the facility should not make placement determinations on identity documents or physical anatomy and should consult medical or mental health professionals as soon as practicable on this assessment.

Does Not Meet (b): The facility was required to determine how to demonstrate that they are not making placement determinations for transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee. The facility was also required to demonstrate consulting with a medical or mental health professional as soon as practicable on transgender/intersex assessments and placement. KCDC was required to provide six examples of the facility utilizing the correct form for each detainee's individualized determinations for compliance review.

Corrective Action (b): On July 11, 2022, the Auditor reviewed and approved the initial CAP provided by the facility pending review of documentation of the handling of transgender and intersex detainees to comply with the requirement of mental health and medical staff involvement with the assessment and it not being based solely on the detainees' anatomy or identity documents. On November 16, 2022, the facility indicated no transgender or intersex detainees had been at the facility during the CAP. The facility provided documentation from policy 3-19 outlining facility guidance on placement determinations for transgender or intersex detainees based on an individualized assessment of the detainee with a reassessment by classification every six months. The policy language was determined to be consistent with this standard. The interview with the HSA, while on site, confirmed medical and mental health practitioner involvement for transgender and intersex detainee placement decisions. The standard is now compliant.

§115. 43 - Protective custody

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

Notes:

(d)(e) Standard 115.43 requires policy protocols for each subpart. Subpart (d) 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 3-19 policy nor the 4-1 Special Management Unit (SMU) policy addresses this subpart requirement. Additionally, subpart (e) requires the facility notify the FOD no later than 72 hours after the initial placement of a detainee in segregation on the basis of vulnerability to sexual abuse which is not included in Policy 3-19 or 4-1.

Does Not Meet (d)(e): The facility must update their written procedures, 3-19 policy, and/or 4-1 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, training must be documented, and procedures and documentation of training provided to the Auditor for compliance review. The facility must include the subpart (e) requirement that the appropriate FOD be notified no later than 72 hours after a detainee is placed into segregation/administrative segregation based on vulnerability in Policy 3-19 or Policy 4-1 or both.

Corrective Action (d)(e): On July 11, 2022, the Auditor reviewed and accepted the initial CAP response provided by the facility which included certain policy revisions, and implementation of the supervisory review form for detainees placed in segregation for vulnerability to sexual abuse. The Auditor also accepted the documented training on this review form for supervisors. On November 16, 2022, the facility again provided policy 3-19, which was revised to include the ICE FOD notification within 72-hours as required in subpart (c) of the standard. The standard is now compliant.

§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) Policy 3-19 requires, "KCDC will provide internal and external ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Reporting may occur via: Inmate request via the kiosk; Inmate Grievance process to the Chief; Verbally speaking with officers or supervisors; Handwritten inmate request; Handwritten note to officers or staff; During inmate evaluations; Reporting to another inmate; To any contractor, volunteer, or employee; Call Rape 1 (# from an inmate phone). KCDC will inform inmates of at least one way to report abuse or harassment to a public or private entity or office that is not part of KCDC and that is able to receive and immediately forward inmate reports of sexual abuse and sexual harassment to KCDC officials. The facility shall provide instructions on how detainees may contact their consular official, the DHS Office of Inspector General [OIG], or as appropriate, another designated office, to confidentially and, if desired, anonymously report these incidents." The Auditor placed a call to the OIG reporting number and the DRIL from three different housing locations while on site and was not able to make the call. In each instance, a call to these numbers required the use of a detainee PIN.

Does Not Meet (a)(b): The facility needs to allow detainees to call the DHS OIG without the use of a PIN to remain anonymous.

Corrective Action (a)(b): On July 11, 2022, the Auditor reviewed the CAP provided by the facility and concurred with the CAP response that the facility would contact the telephone company so the telephones can be used to call the DHS OIG reporting number and the DRIL without the use of a PIN to report a sexual abuse allegation. December 27, 2022, the Auditor reviewed an email provided by the facility indicating the PREA hotline number 6500 and the DHS OIG hotline number 6200 no longer require the detainee to enter a PIN to complete a call. Additionally, the email confirmed that the Chief of Operations conducted a phone system test to verify this information as valid. 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:

(a)(b)(c) Policy 3-19 requires, "KCDC will protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff. The PREA coordinator will monitor, in writing that all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations are protected from retaliation by other inmates or staff. KCDC will utilize multiple protection measures, such as housing changes or transfers for inmate victims or abusers, removal of alleged staff or inmate abusers from contact with victims, and emotional support services for inmates or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. For at least 90 days following a report of sexual abuse, the PREA coordinator will monitor the conduct and treatment of inmates or staff who reported the sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by inmates or staff and will act promptly to remedy any such retaliation. Items

the agency should monitor include any inmate disciplinary reports, housing, or program changes, negative performance reviews or reassignments of staff. The classification officer will continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of inmates, such monitoring will also include periodic status checks. If any other individual who cooperates with an investigation expresses a fear of retaliation, the classification officer will take appropriate measures to protect that individual against retaliation. KCDC's obligation to monitor will terminate if the investigation determines that the allegation is unfounded." The interview with the PSA Compliance Manager confirmed that KCDC 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 conduct retaliation monitoring following every allegation of sexual abuse per the DHS standard subpart (b)(c) and policy 3-19 requirements. The Auditor will need to verify retaliation monitoring for staff, as well as detainees, with at least five examples of completed retaliation monitoring.

Corrective Action (a)(b): On July 11, 2022, the Auditor reviewed the initial response provided by the facility and concurred with the CAP. The Auditor required five examples of the retaliation monitoring document being used during the CAP. On November 16, 2022, the facility informed that KCDC had no allegations of sexual abuse alleged during the CAP to demonstrate use of the new form. Based on the implementation of the 30/60/90-day retaliation monitoring forms for staff and detainees, the facility is now compliant with the standard.

§115. 71 - Criminal and administrative investigations

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

Notes:

(a)(b)(c)(e)(f) Policy 3-19 requires, "When the KCDC conducts its own investigations into allegations of sexual abuse and sexual harassment, it will do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Where sexual abuse is alleged, the agency will use investigators who have received special training in sexual abuse investigations. Upon conclusion of a criminal investigation where the allegation was substantiated, or in instances where no criminal investigation has been completed, 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 ICE Office of Professional Responsibility will typically be the appropriate investigative office within DHS, as well as the DHS OIG in cases where the DHS OIG is conducting an investigation. For administrative investigations, the Investigator will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; will interview alleged victims, suspected perpetrators, and witnesses; and will review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the investigator will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and will not be determined by the person's status as inmate or staff. No investigator will require an inmate who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. Will include an effort to determine whether staff actions or failures to act contributed to the abuse; and will be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. KCDC will retain all written reports for as long as the alleged abuser is incarcerated or employed by the KCDC, plus five years. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation. A jail investigator will be assigned to investigations outside of KCDC."

The Facility Investigator stated that upon every allegation of sexual assault, he notifies the OCLEO 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 provides 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. He informed the Auditor that the departure of the abuser or victim from ICE custody

or employment would not end the investigation. There were four allegations reported during the audit period that were handled administratively and not determined criminal by the OCLEO. The Auditor conducted a thorough review of the investigative documents. KCDC had two case files with documentation of the investigations, including the allegation, witness statements, and relied upon information. The Facility Investigator interview confirmed, when completed, retaliation monitoring and the incident review would become part of the investigative file. There were no files completed on two of the investigations. A synopsis of the allegation was summarized in a two-page document, by the Investigator, with a determination being made with the allegation. This was found in both instances where there was no physical file beyond the type- written overview of the incident. As noted in 115.22, two cases of sexual assault were inadequately documented. The current Investigator confirmed at the time of those two cases, he was not really sure of what his overall responsibilities were with regard to ICE investigations and Kay County inmate investigations; however, since that time, he has learned what these responsibilities entail and was able to articulate these responsibilities to the Auditor during his interview. As noted earlier, this policy was approved by the AFOD.

Does Not Meet (c): This standard subpart requires the facility to document each investigation by a written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment, and investigative facts and finding. The Investigator stated these documents would typically make up the investigative file along with retaliation monitoring and an incident review. They were not present in two of the allegations made. KCDC has an investigative document (form) that the PSA Compliance Manager and Facility Investigator indicated is used for all investigations that was not used in these two instances. To become compliant, the facility must document each investigation by written report using the facility's designated investigative document (form) to record the required information on all future investigations and present to the Auditor for compliance review during the CAP period.

Corrective Action (c): On July 11, 2022, the Auditor reviewed the initial response provided by the facility and concurred with the CAP. On November 16, 2022, the facility informed that KCDC had no allegations of sexual abuse during the CAP to demonstrate use of the new form or review of an investigative file. Based on implementation of the investigative checklist, the facility is now compliant with the standard.

§115. 76 - Disciplinary sanctions for staff

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

Notes:

(a)(b) The Auditor reviewed policy 3-19 that requires, staff be subject to disciplinary or adverse action, up to and including removal from their position, for substantiated allegations of sexual abuse or for violating ICE or facility sexual abuse rules, policies, or standards. Removal from their position is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse. The 3-19 policy was approved by the AFOD. The interviews with the Director and the HR Manager confirmed removal from their position at KCDC and from 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. As noted earlier in the report, KCDC had one allegation of sexual abuse made against staff. The Auditor's investigative file review found this allegation against staff was determined unfounded at the conclusion of that investigation.

Does Not Meet (a): Policy required by standard does not address "removal from Federal service" and must be included in a policy update. The Auditor will need to be provided a copy of policy change for compliance determination.

Corrective Action (a): On July 11, 2022, the Auditor reviewed the initial response from the facility which provided policy 3-19 revision to include "may be removed from federal service" as the sanction for violation of the zero-tolerance policy. The standard is now compliant.

§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) Policy requires, "If screening 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. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of 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." As noted in 115.41, intake, staff was utilizing the wrong form during the detainee vulnerability assessment. The form they utilized asked about prior victimization but not prior

abusiveness. Both intake staff confirmed that when staff learn a detainee was a victim of sexual abuse, they refer the detainee to a qualified Medical or Mental Health practitioner for follow-up as appropriate. Both indicated notifications are typically done by email, telephone call, or discussion with medical staff in the intake area at the time.

The interview with the HSA confirmed medical staff, upon the detainee's arrival, ask detainees about prior abusiveness and victimization. If the detainee answers in the affirmative, a mental health follow-up is initiated, with the detainee typically seeing someone from mental health no later than two working days of the referral.

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 one detainee who disclosed prior victimization. He indicated he was offered and received medical/mental health contact within two days. His medical record was reviewed and confirmed he was seen within 48 hours of his arrival.

Does Not Meet (a): This standard requires, "if the assessment pursuant to 115.41 indicates that a detainee has experienced prior victimization or perpetrated sexual abuse" a referral to a qualified medical or mental health practitioner shall be made. The risk assessment form utilized at the time of the site visit did not address perpetrated abusiveness; therefore, detainees were not identified for this purpose, who may have required a referral. The PSA Compliance Manager ensured intake staff was using the correct form during the site visit. However, for compliance determination, the Auditor will need to see six examples of the correct risk assessment form being utilized, and documentation of any detainee, identified as having perpetrated sexual abuse, receiving a referral to a qualified medical or mental health practitioner.

Corrective Action (a): On July 11, 2022, the Auditor reviewed the initial facility response provided and concurred with the CAP. On November 16, 2022, the Auditor was provided an updated assessment form noting referral to medical and/or mental health staff as required by the standard subpart for prior sexual abuse victimization and perpetrators of sexual abuse. The facility received no detainees noting abusiveness or prior victimization during the CAP. Based on implementation of the reviewed form, the standard is now compliant.

§115. 86 - Sexual abuse incident reviews

Outcome: Does not Meet Standard

Notes:

(a)(b) Policy 3-19 requires, "The facility will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review will ordinarily occur within 30 days of the conclusion of the investigation. The review team will include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The review will consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; 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; Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; Assess the adequacy of staffing levels in that area during different shifts; Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and Prepare a report of its findings, making any recommendations for improvement, and submit such report to the facility head and PREA coordinator. KCDC will implement the recommendations for improvement or will document its reasons for not doing so."

The Auditor interviewed a member of the Incident Review Team (IRT), who indicated an incident review is conducted on every allegation of sexual abuse, with the review documented in writing regardless of the outcome of the investigation. The Auditor reviewed the four allegations reported within the audit period, and there were no incident reviews completed for these allegations.

Does Not Meet (a)(b): The facility needs to conduct incident reviews on all allegations within 30 days after the conclusion on the investigation as required by the standard and the facility's 3-19 policy. The facility must complete an incident review on the four allegations that were investigated during the audit period and provide to the Auditor for compliance review. Additionally, the facility must provide three examples of completed incident reviews for any allegations investigated within the CAP period to determine if they were completed within 30 days after the investigation concluded.

Corrective Action (a)(b): On July 11, 2022, the Auditor reviewed the initial facility response which did not include documentation to support subpart (b) requirements were considered during the incident review. The Auditor requested revised documentation and completed incident reviews for the four allegations. On December 27, 2022, the Auditor

reviewed the documentation provided by the facility and found the review conducted on case 2022-001 compliant. However, the facility did not provide a review for the other three cases. The facility responded, "Out of the allegations filed during audit period 3 of 4 reported were unfounded which would not require an IRT to overview." This response is incorrect and does not comply with the requirements of this standard. The facility is missing reviews for the remaining three (unfounded) cases. DHS Standard 115.86 (a) requires a review be completed on every investigation of sexual abuse. Therefore, this standard remains non-compliant.

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 December 28, 2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) January 10, 2023

Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) January 11, 2023

Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	4/12/2022	**To:**	4/14/2022
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:	Chicago Field Office
Field Office Director:	Sylvie Renda
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	101 W. Ida B Wells Drive, Suite 4000, Chicago, IL 60605
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:	Kay County Detention Center		
Physical address:	1100 W. Dry Rd, Newkirk Ok, 74601		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	580-362-3393		
Facility type:	IGSA		
PREA Incorporation Date:	5/24/2019		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	580-362-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	CIT/PREA Coordinator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	580-761-

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Kay County Detention Center (KCDC) was conducted from April 12, 2022, through April 14, 2022. The audit was performed 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 U.S. Immigration and Customs 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 the previous 12 months: April 14, 2021, through April 14, 2022. KCDC is operated by the Kay County Commission through a seven-person Board of Trustees. This was the first PREA audit for the facility located in Newkirk, Oklahoma. The facility processes adult male detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the KCDC are from Mexico, Guatemala, and Nicaragua.

On April 12, 2022, the ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the entrance briefing held in the facility visiting room, via telephone, and then turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) Captain, KCDC
(b) (6), (b) (7)(C) Master Sergeant, KCDC
(b) (6), (b) (7)(C) Prevention of Sexual Abuse (PSA) Compliance Manager, KCDC
(b) (6), (b) (7)(C) Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU - via telephone
(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE/Enforcement and Removal Operations (ERO)
Thomas Eisenschmidt - Certified PREA Auditor, Creative Corrections, LLC

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 KCDC is 3-19 PREA/SAPPI Local and Contract. All documentation, policies, and the PAQ were reviewed by the Auditor prior to the site visit. A tentative daily schedule was provided by the Team Lead 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

KCDC is a low custody IGSA facility operated by Kay County Detention staff. The facility, with a rated capacity of 344 detainees, had 48 male detainees present on the first day of the audit. This secure facility is shared with Kay County inmates. At the time of the site visit, the facility had two large 30 detainee dorms (Labeled 1 and 2) and two 16 double bed celled pods (labeled K and L). Both these living areas have an upper and lower floor. The dorm areas have two toilets and two showers on each floor. Each of the cells has a toilet, and there are two showers per floor. There are 16 segregation cells on site, but these cells are for the inmates also held at KCDC for the county. There is no comingling of detainees with the inmates. If segregation becomes necessary for any detainee, the two secure booking cells would be utilized. KCDC also has 3 beds in their 24-hour medical area. (b) (7)(E) The showers and toilets in each of the living areas have an obstructed view by staff monitoring cameras. These areas are pixelated on the staff monitors, which was confirmed by the Auditor. All detainees arriving at KCDC come through the facility Sallyport and then are moved to the detainee processing area.

The detainee in-processing area consists of one very large room. 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 if they have not received a COVID-19 vaccination.

During the site visit, the Auditor observed signage requiring cross-gender staff to announce themselves prior to entering the living areas. When a female staff member needs to enter the male detainee living area, they must announce themselves prior to entering. During the three days the Auditor was present this practice was observed.

According to the PAQ and the interview with the PSA Compliance Manager, the staff compliment at KCDC are Kay County Detention Center staff and contractors (employed by TurnKey Health Services). There are 52 security staff, 6 Medical Staff, and 4 Mental Health Staff. The Director, Administrative Assistant (Human Resources), and the PSA Compliance Manager indicated KCDC has no unescorted contractors at the facility. Due to the pandemic, there have been no volunteers at KCDC 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 (Detention Officers) including first-line supervisors, and 20 specialized staff. The specialized staff included: The Director, PSA Compliance Manager, Administrative Assistant, Training Officer, Intake staff (2), Administrative Investigator, Criminal Investigator, Grievance Coordinator, Classification Supervisor, Victim Advocate, Retaliation Monitor, Incident Review team member, Contractors (2), Non-security first responders (2), ICE ERO SDDO (1), Medical staff (1), and Mental Health staff (1). A total of 20 random detainees were interviewed as well. Ten of these 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. There were also no detainees alleging sexual abuse present at the facility for interview either. The Auditor interviewed one detainee who disclosed prior victimization during their risk assessment.

The Auditor was provided by the Team Lead with an Excel spreadsheet, indicating KCDC had four allegations of sexual abuse during the audit period. Of the four reported allegations, three were detainee-on-detainee, and one was staff-on-detainee. All four allegations were investigated, and the cases were closed. The one case involving staff was determined to be unfounded. Of the three detainee-on-detainee allegations, two were determined to be unfounded, and one unsubstantiated at the conclusion of the investigations. The Auditor conducted a thorough review of all four investigative files. During the site visit, the Auditor also reviewed 10 employee HR files, 10 employee training files, 10 detainee detention files and 4 detainee medical files.

On April 14, 2022, an exit briefing was held in the KCDC visiting room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing (via Telephone) and then turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) Captain, KCDC
(b) (6), (b) (7)(C) Master Sergeant, KCDC
(b) (6), (b) (7)(C) PSA Compliance Manager, KCDC
(b) (6), (b) (7)(C) ICE/OPR/ERAU Section Chief (via telephone)
(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU (via telephone)
(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU
(b) (6), (b) (7)(C) SDDO, ICE/ERO
Thomas Eisenschmidt - Certified PREA Auditor, Creative Corrections, LLC
(b) (6), (b) (7)(C) - APM, Certified PREA Auditor, Creative Corrections, LLC (via telephone)

The Auditor spoke briefly about the staff and detainee knowledge of the KCDC 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) prior to making a final determination on compliance. 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: **1**
§115.31 Staff training

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

Number of Standards Met: **25**
§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
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.71 Criminal and Administrative Investigations
§115.73 Reporting to detainees
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection

Number of Standards Not Met: **13**
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.67 Agency protection against retaliation
§115.71 Criminal and Administrative Investigations
§115.76 Disciplinary sanctions for staff
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

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

Notes:

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 3-19 that states, "The Kay County Detention Center has a zero-tolerance standard for the incidence of inmate rape and sex-related offenses and attempts thereof and will make every effort to prevent these incidents. The Detention Center will strictly enforce all federal and state laws regarding inmate sexual misconduct, threats of sexual assault or intimidation by providing clear definitions of prohibited conduct, establishing uniform methods of the prompt reporting and investigation of allegations of sex related offenses or threats, identification of predators, protection of victims and prescribing sanctions for substantiated sexual offenses as well as false allegations." The Auditor was provided documentation that the 3-19 policy was reviewed and approved by the Assistant Field Office Director (AFOD). Random staff and detainees interviewed during the site visit were aware of this zero-tolerance policy.

Recommendation (c): Policy 3-19 PREA/SAPPI Local and Contract, uses the term inmate throughout. The Auditor recommends that the policy be updated to include detainees, particularly on those procedures and processes that are pertinent to DHS PREA Standards.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 3-19, that requires, "The facility administrator shall designate a Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager) who shall 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." The KCDC PSA Compliance Manager confirmed he is the point of contact for the agency's PREA Coordinator and has sufficient time and authority to oversee efforts for the facility to comply with the zero-tolerance policy. He also stated he reports to the Director on all PREA related matters. The Director confirmed the PSA Compliance Manager reports directly to him on all matters related to PREA. The facility provided an organizational chart with the PSA Compliance Manager position designated 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 these subparts of the standard based on review of policy 3-19 that requires, "The facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The facility administrator shall determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, the facility shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors." The Director confirmed that KCDC staffing levels for the supervision of the detainees are established as part of the contract agreement between ICE and the Board of Trustees. He stated that KCDC staffing levels are based on direct supervision of the detainees. The PSA Compliance Manager and Watch Commander indicated the detainee supervision posts are never closed. The Director confirmed that the facility cameras (120) are utilized to augment staff supervision. The Auditor reviewed the daily supervision coverage documents and during the three days on-site, observed supervision as described during interviews with each of them. The Auditor was provided an annual staffing review for 2021, as described by policy 3-19, dated 4-12-2022.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 3-19 that requires, "Supervisors make frequent unannounced security inspections to identify and deter sexual abuse of detainees. Inspections will occur on night as well as day shifts. Staff are prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility." The Auditor interviewed four supervisors during the site visit. Each stated they make rounds daily on each of their eight-hour shifts in every area of the facility where detainees are allowed access. These rounds are conducted hourly in every area detainees are located. They also indicated these rounds are documented in daily log sheets. The Auditor randomly checked copies of these hourly log sheets and found these rounds documented. The Auditor also interviewed random security staff who confirmed their knowledge of the prohibition, in policy, of alerting other staff that the supervisor is conducting rounds. They indicated that they are also required to make rounds in their areas and log them as well. The Auditor observed these log sheets during the three-day site visit.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The PAQ, the Auditor observations, and interviews conducted with the Director and PSA Compliance Manager confirmed KCDC does not accept juveniles or family detainees; therefore, the Auditor has determined this standard is not applicable.

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

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

Notes:

(b)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 3-19 that requires, "Pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat down search is required or in exigent circumstances. All pat-down searches by staff of the opposite gender shall be documented." The random security staff interviewed (12) confirmed their awareness that cross-gender pat-down searches are not permitted except in exigent circumstances and must be documented. KCDC had no cross-gender searches performed during the audit period, as verified in the log by the Auditor.

(c) This subpart is not applicable as KCDC is an adult male facility.

(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 3-19 that requires, "Strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches shall be documented." The Director and PSA Compliance Manager stated there were no instances of cross-gender strip searches or body cavity searches conducted during the audit period; however, had there been, these would have been documented. KCDC has no juvenile detainees, as previously noted. The random security staff (12) interviews confirmed their knowledge of the facility strip/cavity search restrictions. They also indicated their search training covered these policies and the standard requirements.

(g) The Auditor determined compliance with this subpart of the standard based on review of policy 3-19 that requires, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." At each entrance to the detainee living areas, there are notices posted to remind female staff of the requirement to announce themselves prior to entering. The 20 random detainees interviewed confirmed that this process is done consistently at their living areas. The interviews with the 12 random security staff confirmed this cross-gender announcement practice. During the site visit, the Auditor observed the announcement practice. As noted in the facility narrative the camera viewing was reviewed and found no privacy concerns. Detainees are instructed to change their clothing in the shower area and bathroom, which was confirmed during the random detainee interviews.

(h) This subpart is non-applicable. KCDC is not a Family Residential Facility.

(i)(j) The Auditor determined compliance with these subparts of the standard based on review of policy 3-19 that requires, "The facility shall not search or physically examine a detainee for the sole purpose of determine the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. KCDC will train officers and staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates. All pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and policy, including officer safety." The Auditor reviewed the training curriculum for security staff at KCDC. Each of the element requirements in this standard and policy were addressed in the curriculum. The 10 random security training files documented the staff members' participation in this training. The 12 random security staff interviews confirmed their knowledge of the specific search requirements and prohibitions when dealing with detainees, including the prohibition of searching any detainee to determine their genital characteristics. They also confirmed the search training they received included cross gender, transgender, and intersex searching techniques in a professional and respectful manner. Search logs indicated there were no searches of detainees for the purpose of determining the detainee's genital characteristics within the audit period. 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: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) The policy 3-19 requires, "KCDC will ensure that inmates with disabilities (including, for example, inmates 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 KCDC's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps will include: Providing access to interpreters who can interpret effectively, accurately, and

impartially, both receptively and expressively, using any necessary specialized vocabulary. That written materials are provided in formats or through methods that ensure effective communication with inmates with disabilities, including inmates who have intellectual disabilities, limited reading skills, or who are blind or have low vision. The PREA Officer will ensure that disabled inmates have access to these materials and programs. KCDC is not required to take actions that it can demonstrate or 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 Americans with Disabilities Act, 28 CFR 35.164. In matters relating to allegations of sexual abuse, each facility shall employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. Each facility shall provide detainees with disabilities and detainees with Limited English Proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse."

The intake process for detainees was detailed to the Auditor by two KCDC intake staff. According to them, each detainee arriving at KCDC receives the ICE National Detainee handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the Kay County Detention Center Handbook, all only available in English and Spanish at KCDC. The facility also provides detainees speaking Spanish and English with two informational videos (PREA and Know Your Rights) that run continuously in the intake area and in each housing unit. The Auditor was also informed by the two intake staff that when the facility is confronted with a detainee who may be hearing impaired or deaf, the required orientation information is either provided to the detainee in writing or through use of the facility text telephone (TTY). If staff is confronted with a detainee who is blind or has limited sight, he would be provided individualized service by a staff member, to include having the information read to him. The Auditor was also informed that if staff encounters any detainee with an intellectual disability, the staff will try to communicate with them to the best of their abilities. If they encounter any difficulty, then the detainee would be referred to a supervisor, medical staff, or mental health staff based on the detainee's limitation.

The Auditor questioned intake staff about how they provide information to a detainee not covered by a language provided by the ICE National Detainee Handbook. They indicated they would utilize their contracted language service. However, they could not demonstrate what information is provided to a LEP detainee not covered by one of these languages. During the site visit, the Auditor was informed by intake staff and supervisors that the ICE National Detainee Handbook and the DHS-prescribed SAA pamphlets were only available only in English and Spanish. KCDC staff was informed by the Auditor that both these resources were available by the Agency in 14 languages and 9 languages, respectively. The PSA Compliance Manager stated to the Auditor that he had finished a manuscript of information to be provided to LEP detainees whose language is not covered by languages provided by the ICE National Detainee Handbook; however, the Auditor did not review the final edition of this manuscript since it was not completed in sufficient time for full implementation and compliance consideration within the audit period. The Auditor reviewed the four sexual abuse allegations and found none of the allegations involved a LEP detainee; therefore, compliance with provision (c) of the standard could not be ascertained through file review. The Auditor interviewed 20 randomly selected detainees. Even though some non-English and Spanish speaking detainees were chosen for interview, during their interview it was determined they understood one of these languages and understood the orientation materials provided. The detainee detention file (10) review documented by signature that the detainees had received the orientation materials.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard as it could not demonstrate it provides detainees who are LEP with language assistance, including through bilingual staff or professional interpretation and translation services, to ensure meaningful access to its programs and activities. To become compliant, the facility needs to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainee who are LEP. The facility needs to provide five samples of intake information provided to detainees speaking a language not covered by the 14 languages covered by the ICE National Detainee Handbook. As previously noted, the PSA Compliance Manager had completed a manuscript that outlines the facility's efforts to prevent, detect, and respond to sexual abuse. The facility must provide evidence of the new process implementation that was developed by the PSA Compliance Manager at the time of the audit, and evidence that the process is being complied with; documentation of the interpretation service used to deliver the manuscript and signature of detainee's participation for the detainee who speak languages other than English and Spanish and must include detainees who speak a language other than one of the 14 languages covered by the ICE National Detainee Handbook.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(e)(f) The Auditor reviewed policy 3-19, Executive Order (EO) 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive, all of which detail suitability requirements for candidate hirings. KCDC policy 3-19 states, "KCDC will not hire or promote anyone who may have contact with inmates, and will not enlist the services of any contractor, who may have contact with inmates, who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. § 1997); Has been convicted of engaging or attempting to engage in sexual activity 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 has been civilly or administratively adjudicated to have engaged in the activity described above. KCDC will also ask all applicants and employees who may have contact with inmates directly about previous misconduct described above 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. KCDC will also impose upon employees a continuing affirmative duty to disclose any such misconduct. Material omissions regarding such misconduct, or the provision of materially false information, will be grounds for termination. Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Unless prohibited by law, KCDC will 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 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 KCDC Administrative Assistant confirmed potential employees are questioned specifically about any misconduct outlined in subpart (a) of this standard. An affirmative response to those questions would automatically disqualify the individual from hiring. She stated the facility would request information from prior institutions where the prospective candidate was previously employed, and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire. She also confirmed 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. The Auditor reviewed 10 employee files and found that KCDC does not require employees on an annual basis during their evaluations to acknowledge by signature that they have not engaged in any activity prohibited by policy or by subpart (a).

Does Not Meet (b): The review of the employee files and the interview with the KCDC Executive Assistant confirmed the facility is not complying with the policy or standard requirement that during 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 Federal Statute 731.202 (b), EO 10450, ICE Directive 6-7.0, and ICE Directive 6-8.0 requires, "the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees prior to being allowed entrance into the facility." It further requires, "a background recheck be conducted every five years on all employees and unescorted contractors." The Administrative Assistant stated that KCDC completes background checks for all staff and contractors prior to hiring. The Auditor reviewed 10 employee files and found background checks completed before contact with any detainee. KCDC is not an immigration only detention facility; therefore, a 5-year background check is not required. ICE staff were not included in the file reviews because there are no ICE staff assigned full-time to KCDC.

§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 KCDC. The Director and the PAQ confirmed the facility have not made any upgrades to the facility or to their technologies during the audit period.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on review of policy 3-19 that requires, "To the extent KCDC is responsible for investigating allegations of sexual abuse, KCDC will follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." The Auditor reviewed the facility's uniform evidence protocol policy and determined it does, in fact, meet the standard's requirement. The Director confirmed the policy outlining the protocol was reviewed and approved by ICE and provided this review documentation. The Facility Investigator confirmed he follows the evidence protocols provided in his training and, as required in policy 3-19, to ensure he obtains the physical evidence needed to properly conduct his administrative investigations. The Agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sexual assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the AFOD would assign an administrative investigation to be conducted. The Auditor found, after the review of four sexual abuse allegations, uniform evidence protocols were followed during the administrative investigations.

(b)(d) Policy 3-19 that states, "Each 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 victims' needs. Each facility administrator shall establish procedures to make available, to the full extent possible, outside victim services following incidents of sexual abuse. As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member will accompany and support the victim through the forensic medical examination process and investigatory interviews and will provide emotional support, crisis intervention, information, and referrals." The Auditor was provided and reviewed a Memorandum of Understanding (MOU) between the Survivor Resource Network (SRN) and KCDC, dated 3/4/2022 with no sunset date. An interview was conducted with a staff member from the SRN. This advocate confirmed her agency provides short-term crisis intervention to victims and survivors of sexual assault, rape, and molestation. KCDC was provided a 24-hour crisis hotline and mailing address for confidential contact with this advocate. The MOU between KCDC and states SRN shall, "Provide inmates with multiple internal ways to privately report sexual abuse and sexual harassment at no cost; Provide follow-up services and crisis intervention contacts to victims of sexual assault at KCDC; Respond to requests from KCDC to provide advocacy when inmates receive a sexual assault forensic exam or medical evaluation from the Sexual Assault Nurse Examiner; Act as a third party reporting agency by responding to calls from KCDC inmates received on the PREA hotline and report those calls to the KCDC administrators; and Respond to requests to provide a medical examination when inmates are in need of a sexual assault forensic exam." The facility Investigator confirmed that when the detainee is first taken to medical, they are provided victim advocate information by either the Investigator, PSA Compliance Manager, and/or medical staff after every report of an allegation. However, the Auditor's review of the documentation associated with the four closed allegations supported that only two alleged victims were offered victim advocacy services.

Does Not Meet (b): The facility reported four sexual abuse investigations during the audit period. In review of those four closed allegations, only two cases had case files and the other two allegations had an investigative summary prepared by the trained investigator. Within the two case files reviewed, the Auditor determined the alleged victims were offered victim advocacy services; however, the Auditor was not able to determine advocate services were provided as required by these subparts in the other two cases. The facility needs to demonstrate that advocate services are offered to each victim of sexual abuse as required by policy and standard.

(c): The Auditor determined compliance with this subpart of the standard based on policy 3-19 that requires, "Where evidentiary or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel." According to the Health Services Administrator (HSA) and the advocate from SRN, a Forensic Nurse Examiner would come either to the facility medical area or examine the victim at the local hospital (Alliance Health Hospital) to perform the forensic examination. The MOU with SRN outlines this forensic examination process. Based on interviews with the PSA Compliance Manager, HSA, review of the facility's PAQ, and investigation file reviews, the facility had no need for forensic examinations during the audit period.

(e): The Auditor determined compliance with this subpart of the standard based on policy 3-19 that requires, "To the extent KCDC itself is not responsible for investigating allegations of sexual abuse; the agency will request that the investigating agency follow the requirements of paragraphs (a) through (d) of this section." The Director and the PSA Compliance Manager confirmed that Oklahoma Certified Law Enforcement Officers (OCLEO) have legal authority and are responsible for conducting criminal investigations at KCDC. During the review of investigative files available, the Auditor observed the OCLEO was notified in each of the allegations of sexual abuse made at KCDC during the audit period. None of the 4 allegations were investigated criminally based on documentation provided. The auditor was provided a written request to OCLEO asking that their officers comply with subpart (a) through (d) of this standard. They had not heard back from the request.

§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:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 3-19 that requires, "The facility shall coordinate with ICE and other appropriate investigative entities to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse. KCDC will ensure that all allegations of sexual abuse or sexual harassment are referred for investigation to Jail Investigations for possible criminal investigations. All investigations must be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators. 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 finding. Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." The agency's policy 11062.2 outlines the evidence and investigation protocols. All investigations are to be reported to the Joint Intake Center (JIC), who assesses allegations to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff.

If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation, and the AFOD would assign an administrative investigation to be completed.

The facility had a total of four allegations: Three incidents were detainee-on-detainee, and one was staff-on-detainee. All four allegations were referred to ICE OPR, and none were deemed criminal. The Auditor reviewed the investigative case files available (2) and determined they were completed in accordance with the standard and policy. The KCDC Investigator was interviewed and found to be very knowledgeable concerning his responsibilities in the investigative process. He also confirmed he assists with outside law enforcement when required.

(c) The protocols for ICE investigations are found on their web page (www.ice.gov/prea), and the investigation process for KCDC is found posted at the facility entrance and in the detainee visiting room. KCDC does not have a website.

(d)(e)(f) The Auditor determined compliance with these subparts of the standard based on policy 3-19 that requires, "When a detainee(s) is alleged to be the perpetrator, it is the facility administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to the Field Office Director, who shall report it to the OPR Joint Intake Center. When an employee, contractor or volunteer is alleged to be the perpetrator of detainee sexual abuse and/or assault, it is the facility administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to the Field Office Director, who shall report it to the OPR Joint Intake Center. The local government entity or contractor that owns or operates the facility shall also be notified." The Auditor interviewed the KCDC SDDO, who indicated that when he is notified by the facility of an allegation of sexual abuse, he would notify the JIC, OPR, and the DHS OIG of the reported allegation. The interviews with the Director and the PSA Compliance Manager indicated the SDDO is notified of all allegations of sexual abuse either in person, email, and/or phone call. The file review confirmed these notifications were completed per policy and the standard's requirement.

§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 policy 3-19 that requires "KCDC will train all employees who may have contact with inmates on: The zero tolerance policy for sexual abuse and sexual harassment; How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; Inmates right to be free from sexual abuse and sexual harassment; The right of inmates and employees to be free from retaliation for reporting sexual abuse and sexual harassment; The dynamics of sexual abuse and sexual harassment in confinement; The common reactions of sexual abuse and sexual harassment victims; How to detect and respond to signs of threatened and actual sexual abuse; How to avoid inappropriate relationships with inmates; How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Employees are advised that sexual conduct between staff and inmates, volunteers, or contractors regardless of consensual status, is prohibited and subject to administrative and disciplinary sanctions including termination. The training unit will document, through employee signature or electronic verification that employees understand the training they have received. All current employees who have not received such training will be trained within one year of the effective date of the PREA standards, and the agency will provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, KCDC will provide refresher information on current sexual abuse and sexual harassment policies." The Auditor reviewed 10 random training files (8 employee and 2 contractors) and found each file contained a signed training certification form. The random 12 KCDC staff and 2 ICE staff interviewed by the Auditor confirmed each had received PREA pre-service training. They also confirmed the instruction they received included the requirements outlined in subpart (a) of the standard. The interview with the KCDC Training Officer and the review of the training curriculum confirmed the subpart (a) requirements are part of the PREA training. Staff indicated, and training documents confirmed, that although the policy requires the training every two years, staff receive it annually exceeding the standard's requirements.

§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 based on policy 3-19 that requires, "KCDC will ensure that all volunteers and contractors who have contact with inmates (or enter the secure portion of the facility) have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The level and type of training provided to volunteers and contractors will be based on the services they provide and level of contact they have with inmates, all volunteers and contractors who have contact with inmates will be notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. KCDC will maintain documentation confirming that temporary contractors, regular contractors, and volunteers understand the training they have received. This documentation will be retained by the training officer." The Training Officer confirmed contractors at KCDC receive the same training all staff members receive. They document, by signature, their understanding of the PREA training that each receives annually. He also stated that the facility has not provided training to volunteers in over two years due to the pandemic.

He informed the Auditor that prior to the pandemic, and once volunteers return, regardless of the service, they will be provided the PREA training curriculum staff and contractors receive. There were no contractors, as defined under subpart (d) at KCDC.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f) Policy 3-19 requires, "During the intake process, inmates will receive information explaining the KCDC's zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. This information is communicated orally and in writing in a language clearly understood by the inmate, prior to assignment to a housing unit. 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. Each facility's sexual abuse or assault prevention and intervention program shall provide detainees who are victims of sexual abuse or assault the option to report the incident or situation to a designated staff member other than an immediate point-of-contact line officer (e.g., the program coordinator or a mental health specialist). The facility shall provide detainees with the name of the program coordinator or designated staff member and information on how to contact him or her. Detainees will also be informed that they can report any incident or situation regarding sexual abuse, assault, or intimidation to any staff member (as outlined above), the DHS Office of Inspector General, and the Joint Intake Center. Methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of contact line officer, the Detention and Reporting Information Line (DRIL), the DHS/OIG and the ICE/OPR investigation processes. The facility shall maintain documentation of detainee participation in the instruction session."

The Auditor's review of the orientation program found that it includes all elements required (1-6) of this standard; however, as noted in 115.16, detainees arriving at KCDC are only provided an ICE National Detainee Handbook, the Kay County Detention Center handbook, the DHS-prescribed SAAPI pamphlet, and are shown a PREA video (PREA and Know Your Rights), all in English or Spanish only. The intake process for detainees was detailed to the Auditor by two KCDC intake staff. Detainees arriving at KCDC receive these resources in these languages only. The Auditor was also informed by these two intake staff that when the facility is confronted with a detainee who may be hearing impaired or deaf, the required orientation information is provided to them in writing or through use of the facility TTY. If staff is confronted with a detainee who is blind or has limited sight, he would be provided individualized service by a staff member to have the information read to him. The Auditor was also informed that if staff encounters any detainee with an intellectual deficiency, the staff will try to communicate to them to the best of their abilities. If they encounter any difficulty, then the detainee would be referred to a supervisor, medical staff, or mental health staff based on the detainee's limitation. The Auditor questioned the intake staff about detainees not speaking one of the languages not represented by the ICE National Detainee Handbook that they have. They indicated they would utilize their contracted language service to provide this information. However, they could not demonstrate what information they provide a LEP detainee not covered by one of these languages. During the site visit, the Auditor was informed by intake staff and supervisors that the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet were available only in English and Spanish at the facility. However, ICE National Detainee Handbook is available in 14 languages (English, Spanish, Punjabi, Russian, Arabic, Chinese, French, Haitian Creole, Portuguese, Hindi, Romanian, Turkish, Bengali, and Vietnamese) and the DHS-prescribed SAAPI pamphlet is available in 9 languages (English, Spanish, Arabic, Chinese, French, Haitian Creole, Hindi, Portuguese, and Punjabi). KCDC staff was informed by the Auditor that both these resources were available by the Agency through ERO in PDF format for printing as needed and distribution to detainees. The PSA Compliance Manager stated to the Auditor that he had finished a manuscript of information to be provided to LEP detainees whose language is not covered by one of the Handbook languages. The Auditor interviewed 20 randomly selected detainees. Even though some non-English and Spanish speaking detainees were chosen to interview, during their interview, it was determined they understood one of these languages (Spanish or English); and therefore, understood the orientation materials provided. The review of the detainee detention files (10) demonstrated by detainee signature that each of the detainees had received the required orientation materials. The Auditor observed DHS prescribed SAA Information pamphlet in Spanish and English was posted in each of the living areas.

Does Not Meet (b)(c): The facility has not demonstrated it provides detainees, speaking a language not covered by the ICE National Detainee Handbook, an orientation program that informs them about the agency's and facility's zero tolerance policies for all forms of sexual assault, to include the six subpart (a) requirements. As previously noted, the PSA Compliance Manager had completed a manuscript that outlines the facility's efforts to prevent, detect, and respond to sexual abuse. The facility must provide evidence of the new process implementation that was developed by the PSA Compliance Manager at the time of the audit, and evidence that the process is being complied with; documentation of the interpretation service used to deliver the manuscript and signature of the detainee's participation for the detainee who speak languages other than English and Spanish and must include detainees who speak a language other than one of the 14 languages covered by the ICE National Detainee Handbook.

(d) The Auditor determined compliance with these subparts of the standard based on policy 3-19 that requires, "The ICE provided sexual assault awareness notice to be posted on all housing-unit bulletin boards, as well as a "Sexual Assault Awareness Information" pamphlet. The facility shall post with this notice the name of the PSA Compliance Manager and information about local organizations that can assist detainees who have been victims of sexual assault, including mailing addresses and telephone numbers (including toll-free hotline numbers where available)." During the site visit, the Auditor observed the required DHS poster with the name of the PSA Compliance Manager in each area of KCDC that detainees have access to, including in all housing areas. These areas also contained

the victim advocate contact information in Spanish and English. The 20 random detainee interviews confirmed their knowledge of these posters and the required information.

§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 based on policy 3-19 that requires, "In addition to the training provided to all employees, KCDC will ensure that, to the extent it conducts sexual abuse investigations; its investigators have received training in conducting investigations in confinement settings." The Auditor interviewed KCDC's primary Investigator. He confirmed receiving specialized training, and his training was documented in his training file. The Investigator's interview confirmed he received his training through the National Institute of Corrections (NIC) (longer version training), and it included a curriculum on working with outside entities. There were four sexual abuse investigations conducted during the audit period. These investigations were conducted by a trained investigator. 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 collection and covers all aspects of 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.

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

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

Notes:

(a)(b) These subparts of the standard do not apply to KCDC as the facility medical department is operated by TurnKey Health Services.

(c) The Auditor determined compliance with these subparts of the standard based on policy 3-19 that requires, "The KCDC's PREA officer will ensure that all full and part-time medical and mental health care practitioners who work in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. The KCDC's programs PREA officer will maintain documentation that medical and mental health practitioners have received the training." The HSA confirmed that all current Medical and Mental Health Practitioners have been provided this training as required by policy. Her interview also confirmed that the KCDC Medical staff are prohibited from participating in sexual assault forensic medical examinations or evidence gathering. The Auditor randomly chose two medical staff training files and found this required training documented in their files. As noted earlier, the 3-19 policy was approved by ICE. Of the four allegations that occurred during the audit period, none required forensic examinations as confirmed by interviews with the medical staff and PSA Compliance Manager.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d) Policy 3-19 requires, "the facility shall assess all detainees on 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. The facility 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. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: 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 policy further states, "Intake screening will take place within 24 hours of arrival at the facility." The PSA Compliance Manager realized that the risk assessment document that was being utilized by the intake staff at the time of the site visit was not the correct document. The document they were using did not address four of the 10 requirements of subparts (c)(d). It is clear that the facility is assessing all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims to satisfy subpart (a); however, the form they have been using does not include four of the required elements for consideration. The review of the 10 detention files found this incorrect document as well. During the site visit, the PSA Compliance Manager had the intake staff end the use of this document and utilize the correct facility assessment document. The 3-19 policy will need to correct the requirement that the assessment be completed within 12 hours instead of the noted 24 hours. The interview with the Classification Officer indicated the classification and housing process is completed within 12 hours of the arrival. The interviews with the random detainees confirmed their classification was completed within their first two hours of arrival at KCDC.

Does Not Meet (c)(d): The risk assessment document the facility was using did not address 4 of the 10 requirements of subparts (c)(d). During the site visit, the PSA Compliance Manager had the intake staff end the use of this document and utilize the correct facility assessment document; however, KCDC must provide six examples of the facility utilizing the correct form during the CAP period for the Auditor's review to ensure this process is fully implemented.

Recommendation (b): The Auditor recommends that the facility policy 3-19 be updated to correct the requirement that the assessment be completed within 12 hours instead of the noted 24 hours.

(e) Policy 3-19 requires, "The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the 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 PSA Compliance Manager confirmed KCDC conducts reassessments on all detainees at the facility between the 60-90-day requirement. The Auditor interviewed 20 random detainees. Seven of these detainees were eligible for this reassessment but indicated during their interview that they did not receive one. The review of their detention files did not demonstrate this reassessment was completed. The four investigative files were reviewed and none of the detainees received a reassessment as a result of the allegation of sexual abuse as required under this subpart.

Does Not Meet (e): The Auditor's review of the four detainee files alleging sexual abuse found no risk assessments completed after report of the allegation. Furthermore, during interview, seven detainees who were eligible for a 60-90-day reassessment indicated they had not received one; the Auditor's review of their related detention files further confirmed there was no reassessment completed. The facility needs to follow both the DHS PREA standard and their 60–90-day reassessment policy requirement. To meet compliance, the facility must perform a reassessment on all detainee victims and alleged abusers as required by policy 3-19 and the standard after an incident of sexual abuse; provide the Auditor at least one completed assessment performed on an alleged abuser and victim; and provide the Auditor with 10 (60-90-day) reassessments completed after implementation of the updated procedures.

(f) The Auditor determined compliance with this subpart of the standard based on policy 3-19 that "Inmates will not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked about mental, physical, or developmental disability, perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, has previously experienced sexual victimization, or inmates' own perception of vulnerability." The PSA Compliance Manager and two intake staff confirmed detainees are not disciplined for refusing to answer any of the questions asked during the risk assessment.

(g) The Auditor determined compliance with this subpart of the standard based on policy 3-19 that requires, "KCDC will control the dissemination within the facility of responses to questions asked in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates." The Classification Officer confirmed appropriate controls are placed on all detainee records and information, including reassessments, which are maintained in the detainee's detention file and secured in the records room file cabinet, under lock and key. The training staff and contractors receive at KCDC includes the requirement to limit reporting of sexual abuse information to only those personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. The 12 random staff interviews confirmed their responsibility of remaining confidential with all information they become knowledgeable about during incidents of sexual abuse, discussing it only with their supervisor or the investigator.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Policy 3-19 requires, "KCDC will use information from the risk screening form to notify housing, bed, work, education, and program assignments. KCDC will attempt to keep separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. KCDC will make individualized determinations about how to ensure the safety of each inmate." As noted in standard 115.41, the risk assessment was not acquiring all the information required in the (c)(d) subparts. Therefore, the facility is not able to make individualized determinations from all information required by the risk assessment.

Does Not Meet (a): As noted in 115.41, the PSA Compliance Manager realized an incorrect form was being used during the site visit and placed the correct form in the intake area. KCDC will need to provide six examples of the facility utilizing the correct form for each detainee's individualized determinations for compliance review.

(b)(c) Policy 3-19 states, "In deciding whether to assign a transgender or intersex inmate to housing and programming assignments, classification will consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems. A transgender or intersex inmate's own view with respect to his or her own safety will be given serious consideration. Placement and programming assignments for each transgender or intersex inmate will be reassessed by the Classification Officer at least twice each year to review any threats to safety experienced by the inmate. The Classification Officer will document the reviews. Transgender and intersex inmates will be given the opportunity to shower separately from other inmates." The interviews with the PSA Compliance Manager and Classification Officer confirmed that KCDC has not had a transgender or intersex detainee at the facility over the past three years. They both indicated that should they receive a transgender or intersex detainee, they would follow policy. Although this standard does not require a policy, both indicated they would follow policy 3-19, which does not have procedures governing that the facility should not make placement determinations on identity documents or physical anatomy and should consult medical or mental health professionals as soon as practicable on this assessment.

Does Not Meet (b): The facility must determine how to demonstrate that they are not making placement determinations solely on the identity documents or physical anatomy and should consult with a medical or mental health professional as soon as practicable on transgender/intersex assessments and placement. KCDC will need to provide six examples of the facility utilizing the correct form for each detainee's individualized determinations for compliance review.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) The Auditor reviewed policy 3-19 that requires, "Inmates at high risk for sexual victimization will 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 classification cannot conduct such an assessment immediately, classification may hold the inmate in involuntary segregated housing (medical) for less than 24 hours while completing the assessment. Classification will assign such inmates to involuntary segregated housing only until an alternative means of separation from likely abusers can be arranged, and such an assignment will not exceed a period of 30 days. Inmates placed in segregated housing for this purpose will have access to programs, privileges, education, and work opportunities to the extent possible. If classification restricts access to programs, privileges, education, or work opportunities, classification will document: The opportunities that have been limited; The duration of the limitation; and the reasons for such limitations. Detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director to determine if ICE can provide additional assistance. Such detainees may be assigned to administrative segregation for protective custody 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." The Director, Chief of Security, and PSA Compliance Manager all stated that the placement of any vulnerable detainee in administrative segregation is not typically done at KCDC. The Director stated that no detainee vulnerable to victimization has been placed in segregation during the audit period and indicated he would move the detainee to another housing unit, to the intake processing area, or contact the AFOD to transfer the detainee. He stated that if segregation were ever used, the policy requirements related to the standard would be followed. He also stated that he would contact the AFOD on all victims placed in administrative segregation within 72 hours. Policy 3-19 was reviewed and approved by the AFOD.

(d)(e) Standard 115.43 requires policy protocols for each subpart. Subpart (d) 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 3-19 policy nor the 4-1 Special Management Unit (SMU) policy addresses this subpart requirement. Additionally, subpart (e) requires the facility to notify the FOD no later than 72 hours after the initial placement of a detainee in segregation on the basis of vulnerability to sexual abuse which is not included in Policy 3-19 or 4-1.

Does Not Meet (d)(e): The facility must update their written procedures, 3-19 policy, and/or 4-1 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, training must be documented, and procedures and documentation of training provided to the Auditor for compliance review. The facility must include the subpart (e) requirement that the appropriate FOD be notified no later than 72 hours after a detainee is placed into segregation/administrative segregation based on vulnerability in Policy 3-19 or Policy 4-1 or both.

§115.51 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) Policy 3-19 requires, "KCDC will provide internal and external ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Reporting may occur via: Inmate request via the kiosk; Inmate Grievance process to the Chief; Verbally speaking with officers or supervisors; Handwritten inmate request; Handwritten note to officers or staff; During inmate evaluations; Reporting to another inmate; To any contractor, volunteer, or employee; Call Rape 1 (# from an inmate phone). KCDC will inform inmates of at least one way to report abuse or harassment to a public or private entity or office that is not part of KCDC and that is able to receive and immediately forward inmate reports of sexual abuse and sexual harassment to KCDC officials. The facility shall provide instructions on how detainees may contact their consular official, the DHS Office of Inspector General, or as appropriate, another designated office, to confidentially and, if desired, anonymously report these incidents." The Auditor placed a call to the OIG reporting number and the DRIL from three different housing locations while on site and was not able to make the call. In each instance, a call to these numbers required the use of a detainee PIN. The interview with the PSA Compliance Manager confirmed each detainee arriving at KCDC 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 (Spanish) during the on-site visit. All indicated they were provided information on sexual safety and reporting in a format they understood upon arrival.

Does Not Meet (a)(b): The facility needs to allow detainees to call the DHS OIG without the use of a PIN to remain anonymous.

(c) The Auditor determined compliance with this subpart of the standard after review of policy 3-19 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 four allegations of sexual abuse investigated during the audit period, one was reported through the DRIL, and the remainder were made to KCDC security staff. The Auditor reviewed all four sexual abuse allegations and for the two cases that had investigative files, each included verbal allegations reported to security staff, who then immediately reported it to a supervisor. These two cases files reviewed documented the allegations in writing.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 3-19 that requires, "Formal grievances related to sexual abuse and assault may be filed at any time during, after, or in lieu of lodging an informal grievance or complaint and with no time limit imposed on when a grievance may be submitted. Written procedures must be implemented for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse or assault. Decisions on grievances shall be issued within five days of receipt and appeals shall be responded to within 30 days. Detainees may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties. All grievances related to sexual abuse and the facility's decision on any such grievance must be forwarded to the Field Office Director." The Auditor interviewed the Grievance Officer, who confirmed all allegations of sexual abuse, made through the grievance office are immediately reported to the PSA Compliance Manager and Director. The alleged detainee victim is immediately taken to medical for assessment. The Auditor was also informed that there is no time limit on when a detainee could file a grievance alleging sexual abuse. The Grievance Officer confirmed that KCDC had no allegations of sexual abuse made through the grievance system by a detainee during the audit period. The Director confirmed that once notified of a sexual abuse allegation through the grievance process, he notifies the AFOD of the allegation, who then notifies the FOD. The interview with the SDDO also confirmed the notification process. The Auditor's review of the four allegations within the audit period confirmed none were made through the grievance process. Over half the detainees interviewed were aware that the grievance process was available to report allegations of sexual abuse. The Kay County Detention Center Detainee Handbook advises detainees that the grievance process is a means for them to report any allegation of sexual abuse.

§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 3-19 that requires, "Each 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 victims' needs. Each facility administrator shall establish procedures to make available, to the full 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 administrator 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 as confidential a manner as possible. The facility shall also 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 earlier, KCDC has an MOU, dated 3-4-2022, with SRN to provide advocacy service, a crisis hotline, forensic support, and legal interview support if requested/needed by the victim. The Auditor spoke with an advocate from SRN, who validated their agency would provide emotional support, crisis intervention and community referrals if requested. She indicated her agency has had contact with detainees at KCDC during the audit period. In each of the investigative files reviewed, 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 this organization in all of the detainee living areas. The advocate, during her interview, confirmed SRN accepts allegations of sexual abuse and reports those allegations to law enforcement and back to the facility. The Auditor observed a notation on the posted advocate information sheets in each of the detainee living areas that SRN counselors are mandatory reporters for allegations of sexual abuse. The KCDC Detainee Handbook and notices by the phones informs detainees to the extent that their calls 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 3-19 that states, "KCDC will establish a method to receive third-party reports of sexual abuse and sexual harassment and will distribute publicly information on how to report sexual abuse and sexual harassment on behalf of an inmate. Inmates may report through [C]all [R]ape telephone number. Citizens may report through Jail Investigations or the Call Rape telephone number." This reporting information is provided in the 3-19 policy, which is posted in the

lobby entrance to KCDC. 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 was one third-party sexual abuse allegation received during the audit period through the DRIL line.

§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 3-19 that requires, "KCDC employees, temporary contractors, regular contractors and volunteers will report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against inmates or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation to their immediate supervisor. Apart from initial reporting to supervisor(s) or Jail Investigations, staff will not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, to make treatment, investigation, and other security and management decisions. Staff must also be able to report the above outside of the chain of command. 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 Auditor interviewed 12 random security staff who 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 through the Director or local law enforcement, 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 3-19 was approved by the AFOD. Of the four allegations reported during the audit period, three were reported to KCDC security staff and one to the DRIL line.

(d) The Auditor determined compliance with this subpart of the standard after review of policy 3-19 that requires, "If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person's statute, KCDC will report the allegation to the designated State or local services agency under applicable mandatory reporting laws." There are no juveniles placed at KCDC. The Director confirmed any vulnerable adult victim of sexual abuse would be immediately reported to the AFOD and law enforcement.

§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 3-19 that requires, "When KCDC learns that an inmate is subject to a substantial risk of imminent sexual abuse, it will take immediate action to protect the inmate." The interview protocols for the Director and random staff specifically question each on how they would respond to a situation where a detainee may be in a substantial risk of sexual abuse. Each of their interviews confirmed they would find the detainee and immediately place him in a secure area for protection. The PAQ and interviews with the Director and PSA Compliance Manager confirmed KCDC 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 based on policy 3-19 that requires, "Upon receiving an allegation that an inmate was sexually abused or assaulted while confined at another facility, the facility administrator shall notify the Field Office Director and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The KCDC Jail Administrator will document that they have provided such notification. The Jail Administrator that receives such notification will ensure that the allegation is investigated in accordance with these standards." The Director informed the Auditor if staff received a report of sexual abuse from a detainee on arrival at KCDC 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 KCDC or any allegations made occurring at other facilities reported to KCDC 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 based on policy 3-19 that requires "Upon learning of an allegation that an inmate was sexually abused, the first security staff member to respond to the report will be required to: Separate the alleged victim and abuser; Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating unless medically required; inmates who have pre-existing conditions will be sent to Medical for a medical review; and, If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating." The 12 security staff interviewees detailed their first responder obligations, as outlined in policy and this subpart when responding to incidents of sexual abuse. In each of the three cases where the alleged victim was responded to initially by a security staff member, it appeared from the investigative file review, the security staff

member followed policy and standard responder requirements. The fourth allegation was received through the Directors' Office via the DRIL. It was referred for investigation per the 3-19 policy.

(b) The Auditor determined compliance with this subpart of the standard based on policy 3-19 that requires "If the first staff responder is not a detention officer, the responder will request that the alleged victim not take any actions that could destroy physical evidence and then notify the detention officer or supervisor." The Auditor interviewed two non-security first responders while on site. Both non-security staff confirmed that if a detainee reported to them that they had been sexually abused, they would ensure the victim and perpetrator were separated, not allow either to destroy evidence, and immediately call for a security staff member. During the interview with the Facility Investigator, concerning the four allegations made during the audit period, he indicated that none were made to a non-security staff member.

§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 3-19 that states, "KCDC will institute the written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among first responders, medical and mental health practitioners, investigators, and Jail Supervisors." The Director and PSA Compliance Manager stated that the 3-19 policy is the KCDC written plan that coordinates actions taken by staff in response to all incidents of sexual abuse at the facility. As previously noted, the 3-19 policy was approved by the AFOD. The investigative files reviewed by the Auditor documented the multidisciplinary and coordinated responses taken by KCDC 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 3-19 that requires, "If a victim is transferred between detention facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services (unless, in the case of transfer to a non-ICE facility, the victim requests otherwise). If the receiving facility is unknown to the sending facility, the sending facility shall notify the Field Office Director, so that he or she can notify the receiving facility." The HSA confirmed that, during the audit period, KCDC has had no detainee victims of sexual abuse transferred between a DHS or non-DHS detention facility. She also stated that KCDC would notify the receiving facility of the need for medical or social services as permitted by law of any sexual assault victim transferred except in the case of transfer to a non-ICE facility and the victim requests otherwise.

§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 based on policy 3-19 that requires, "Staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of the investigation." The PSA Compliance Manager and Director both confirmed that any employee, contractor, or volunteer who was an alleged perpetrator of sexual abuse of a detainee would be removed from any further contact with detainees pending the investigation outcome. KCDC had one allegation of sexual abuse made against a staff member during the audit period. There was no need for the staff member to be removed from his duties because the staff member was not at work when the allegation was received, and the investigation was completed before his next scheduled workday.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Policy 3-19 requires, "KCDC will protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff. The PREA coordinator will monitor, in writing that all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations are protected from retaliation by other inmates or staff. KCDC will utilize multiple protection measures, such as housing changes or transfers for inmate victims or abusers, removal of alleged staff or inmate abusers from contact with victims, and emotional support services for inmates or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. For at least 90 days following a report of sexual abuse, the PREA coordinator will monitor the conduct and treatment of inmates or staff who reported the sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by inmates or staff and will act promptly to remedy any such retaliation. Items the agency should monitor include any inmate disciplinary reports, housing, or program changes, negative performance reviews or reassignments of staff. The classification officer will continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of inmates, such monitoring will also include periodic status checks. If any other individual who cooperates with an investigation expresses a fear of retaliation, the classification officer will take appropriate measures to protect that individual against retaliation. KCDC's obligation to monitor will terminate if the investigation determines that the allegation is unfounded." The interview with the PSA Compliance Manager confirmed that KCDC 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 conduct retaliation monitoring following every allegation of sexual abuse per the DHS standard subpart (b)(c) and policy 3-19 requirements. The Auditor will need to verify retaliation monitoring for staff, as well as detainees, with at least five examples of completed retaliation monitoring.

§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 3-19 that requires, "Victims and vulnerable detainees shall be housed in a supportive environment that represents the least restrictive housing option possible (e.g. in a different housing unit, transfer to another facility, medical housing, or protective custody), 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. Victims may not be held for longer than five (5) days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim. The facility shall notify the appropriate ICE field office director whenever a detainee victim, or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hrs. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault." The Director confirmed the use of administrative segregation at KCDC for any detainee victim of sexual abuse or based on their vulnerability to sexual abuse or assault would be highly unlikely. 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 him 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 the facility at the time of the on-site visit to interview.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f) Policy 3-19 requires, "When the KCDC conducts its own investigations into allegations of sexual abuse and sexual harassment, it will do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Where sexual abuse is alleged, the agency will use investigators who have received special training in sexual abuse investigations. Upon conclusion of a criminal investigation where the allegation was substantiated, or in instances where no criminal investigation has been completed, 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 ICE Office of Professional Responsibility will typically be the appropriate investigative office within DHS, as well as the DHS OIG in cases where the DHS OIG is conducting an investigation. For administrative investigations, the Investigator will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; will interview alleged victims, suspected perpetrators, and witnesses; and will review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the investigator will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and will not be determined by the person's status as inmate or staff. No investigator will require an inmate who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. Will include an effort to determine whether staff actions or failures to act contributed to the abuse; and will be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. KCDC will retain all written reports for as long as the alleged abuser is incarcerated or employed by the KCDC, plus five years. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation. A jail investigator will be assigned to investigations outside of KCDC."

The Facility Investigator stated that upon every allegation of sexual assault, he notifies the OCLEO 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 provides 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. He informed the Auditor that the departure of the abuser or victim from ICE custody or employment would not end the investigation. There were four allegations reported during the audit period that were handled administratively and not determined criminal by the OCLEO. The Auditor conducted a thorough review of the investigative documents. KCDC had two case files with documentation of the investigations, including the allegation, witness statements, and relied upon information. The Facility Investigator interview confirmed, when completed, retaliation monitoring and the incident review would become part of the investigative file. There were no files completed on two of the investigations. A synopsis of the allegation was summarized in a two-page document, by the Investigator, with a determination being made with the allegation. This was found in both instances where there was no physical file beyond the type-written overview of the incident. As noted in 115.22, two cases of sexual assault were inadequately documented. The current Investigator confirmed at the time of those two cases, he was not really sure of what his overall responsibilities were with regard to ICE investigations and Kay County inmate investigations; however, since that time, he has learned what these responsibilities entail

and was able to articulate these responsibilities to the Auditor during his interview. As noted earlier, this policy was approved by the AFOD.

Does Not Meet (c): This standard subpart requires the facility to document each investigation by a written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment, and investigative facts and finding. The Investigator stated these documents would typically make up the investigative file along with retaliation monitoring and an incident review. They were not present in two of the allegations made. KCDC has an investigative document (form) that the PSA Compliance Manager and Facility Investigator indicated is used for all investigations that was not used in these two instances. To become compliant, the facility must document each investigation by written report using the facility's designated investigative document (form) to record the required information on all future investigations and present to the Auditor for compliance review during the CAP period.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with this standard after review of policy 3-19 that requires, "KCDC investigators will impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated." The KCDC Investigator confirmed the standard used when determining a sexual abuse investigation is substantiated is the preponderance of the evidence. In review of the documentation found in the two investigative files and the summaries from the other two that KCDC provided the Auditor 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 3-19 that requires, "Following an investigation into an inmate's allegation of sexual abuse the investigator will inform the inmate as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." The Auditor provided the Team Lead with the names of the detainee victims from the four allegations investigated during the audit period. In each of the cases, the detainee was provided the result of the investigation outcome.

§115.76 - Disciplinary sanctions for staff.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) The Auditor reviewed policy 3-19 that requires, "Staff shall be subject to disciplinary or adverse action, up to and including removal from their position, for substantiated allegations of sexual abuse or for violating ICE or facility sexual abuse rules, policies, or standards. Removal from their position is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse." The 3-19 policy was approved by the AFOD. The interviews with the Director and the HR Manager confirmed removal from their position at KCDC and from 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. As noted earlier in the report, KCDC had one allegation of sexual abuse made against staff. The Auditor's investigative file review found this allegation against staff was determined unfounded at the conclusion of that investigation.

Does Not Meet (a): Policy required by standard does not address "removal from Federal service" and must be included in a policy update. The Auditor will need to be provided a copy of policy change for compliance determination.

(c)(d) The Auditor determined compliance with these subparts of the standard after review of policy 3-19 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, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies." The Director and Executive Assistant indicated all allegations of sexual abuse are immediately reported to the OCLEO, regardless if the staff member resigns or not. There were no reported terminations of any KCDC employee for violation of the facility's zero-tolerance policy. The one allegation involving a staff member during the audit period was determined to be unfounded.

§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 3-19 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." The Director confirmed that any contractor or volunteer suspected of perpetrating sexual abuse at KCDC would be removed from all duties pending the outcome of the investigation. He also stated he would consider whether to prohibit further

contact with detainees by any contractor or volunteer who had not engaged in sexual abuse but had violated other provisions within the 3-19 policy. He confirmed that there were no reported incidents at KCDC requiring the removal of any contractor or volunteer during the audit period, and had there been, he would have reported the incident to the OCLEO, the FOD, and any relevant licensing body. There were no allegations of sexual abuse 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 based on policies 3-19 and 3-1, Inmate Discipline, that require, "Detainees shall be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse, consistent with the requirements of policy 3.1 "Disciplinary System". The facility 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. If a detainee is mentally disabled or mentally ill but competent, a disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Inmates may appeal through the inmate grievance procedure to the Jail Administrator, in writing, within typical grievance time guidelines not to exceed fifteen days from the date of being advised. The inmate will be advised of this right to appeal by the Lieutenant at the time the sanction is announced. The Jail Administrator or designee may affirm or reverse the decision outright, return the decision to the Lieutenant for further proceedings, or modify (but not increase) the sanction imposed. A decision will be made within five days. The Jail Administrator will consider the merit of the appeal based on whether there was substantial evidence to support the charges, whether there was substantial compliance with applicable discipline policies and procedures, and whether the sanction imposed was proportionate to the rule violation." The Director and PSA Compliance Manager confirmed that the disciplinary process at KCDC allows for progressive levels of reviews, appeals, procedures, and the entire process is documented. They also confirmed that staff assistance is provided upon any detainee's request. There were three allegations of detainee-on-detainee sexual abuse, with none substantiated upon completion of the investigation; therefore, the disciplinary process was not used.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Policy requires, "If screening 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. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of 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." As noted in 115.41, intake, staff was utilizing the wrong form during the detainee vulnerability assessment. The form they utilized asked about prior victimization but not prior abusiveness. Both intake staff confirmed that when staff learn a detainee was a victim of sexual abuse, they refer the detainee to a qualified Medical or Mental Health practitioner for follow-up as appropriate. Both indicated notifications are typically done by email, telephone call, or discussion with medical staff in the intake area at the time. The interview with the HSA confirmed medical staff, upon the detainee's arrival, ask detainees about prior abusiveness and victimization. If the detainee answers in the affirmative, a mental health follow-up is initiated, with the detainee typically seeing someone from mental health no later than two working days of the referral.

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 one detainee who disclosed prior victimization. He indicated he was offered and received medical/mental health contact within two days. His medical record was reviewed and confirmed he was seen within 48 hours of his arrival.

Does Not Meet (a): This standard requires, "if the assessment pursuant to 115.41 indicates that a detainee has experienced prior victimization or perpetrated sexual abuse" a referral to a qualified medical or mental health practitioner shall be made. The risk assessment form utilized at the time of the site visit did not address perpetrated abusiveness; therefore, detainees were not identified during use of this assessment form as perpetrators, who may have required a referral. The PSA Compliance Manager ensured intake staff was using the correct form during the site visit. However, for compliance determination, the Auditor will need to see six examples of the correct risk assessment form being utilized, and documentation of any detainee, identified as having perpetrated sexual abuse, receiving a referral to a qualified medical or mental health practitioner. The facility has sufficiently demonstrated identification and referral of prior victims during the screening process.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on policy 3-19 that requires, "Detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All treatment services, both emergency and ongoing, 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." The Auditor reviewed information on the four allegations made during the audit period and confirmed that each of the four alleged victims was brought to the medical unit and evaluated by medical staff and/or mental health the same day.
The interview with the HSA confirmed that any detainee alleging sexual abuse would be seen by Medical and/or Mental Health staff. The services received would be consistent with community standards, and at no cost to the detainee regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

§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)(g) The Auditor determined compliance with these subparts of the standard after review of policy 3-19 that requires, "Each 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. The 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. The facility shall provide such victims with medical and mental health services consistent with the community level of care. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. 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. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. The facility shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." The HSA confirmed any detainee who experiences sexual abuse while in detention would receive medical and mental health services and treatment, including follow-up 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 tests and medication for sexually transmitted infections as needed. The interviews with the Director and PSA Compliance Manager and review of the PAQ confirmed KCDC is a low custody, adult males IGSA facility. The interviews further confirmed abusers would not be housed at KCDC; however, if a detainee was found to have abused another detainee, mental health services would be offered to him prior to his removal from the facility, according to the HSA, Director and PSA Compliance Manager. KCDC had four allegations of sexual abuse reported during the audit period. None of these allegations were substantiated. None of those detainees were present at the facility at the time of the site visit to interview. The Auditor reviewed their medical records and noted the detainees were seen by medical/mental health as a result of the allegations.

§115.86 - Sexual abuse incident reviews.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b) Policy 3-19 requires, "The facility will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review will ordinarily occur within 30 days of the conclusion of the investigation. The review team will include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The review will consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; 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; Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; Assess the adequacy of staffing levels in that area during different shifts; Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and Prepare a report of its findings, making any recommendations for improvement, and submit such report to the facility head and PREA coordinator. KCDC will implement the recommendations for improvement or will document its reasons for not doing so."

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 of the investigation. The Auditor reviewed the four allegations reported within the audit period, and there were no incident reviews completed for these allegations.

Does Not Meet (a)(b): The facility needs to conduct incident reviews on all allegations within 30 days after the conclusion on the investigation as required by the standard and the facility's 3-19 policy. The facility must complete an incident review on the four allegations that were investigated during the audit period and provide to the Auditor for compliance review. Additionally, the facility must provide three examples of completed incident reviews for any allegations investigated within the CAP period to determine if they were completed within 30 days after the investigation concluded.

(c) Policy 3-19 requires, "Each facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, Field Office Director, or his or her designee, for transmission to the ICE PSA Coordinator." The PSA Compliance Manager indicated that KCDC had conducted this annual review but did not present the document to the Auditor.

Does Not Meet (c): The Facility must comply with standard and policy requirements and supply the Auditor with the 2021 annual review and demonstrate it was provided to the FOD and the agency's PSA Coordinator.

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

(a) The Auditor determined compliance with the standard based on policy 3-19 that requires, "The facility shall maintain in a secure area all case records associated with claims of sexual abuse or assault, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary." The PSA Compliance Manager confirmed that data collected for any investigation of sexual abuse is securely maintained in his office under double lock and key with access restricted to only staff with a need to review. He indicated the records are retained for at least ten years, after the date of the initial collection, unless federal, state, or local law requires otherwise. The Auditor viewed this secure location during the site visit.

§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 was allowed 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:	1
Number of standards met:	25
Number of standards not met:	13
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 6/14/2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) 6/15/2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 6/15/2022
Program Manager's Signature & Date