PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	1/27/2021	**To:**	1/29/2021
AUDITOR INFORMATION			
Name of auditor:	Sabina Kaplan	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	914-474-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-381-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Miami Field Office		
Field Office Director:	Michael W. Meade		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	18201 SW 12th Street, Miami Florida 33194		
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:	Krome North Service Processing Center		
Physical address:	18201 SW 12 Street, Miami Florida 33194		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	(305) 207 2001		
Facility type:	SPC		
PREA Incorporation Date:	5/29/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	305-207-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Senior Detention and Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	305-207-(b) (6), (b)
ICE HQ USE ONLY			
Form Key:	29		
Revision Date:	02/24/2020		
Notes:	Click or tap here to enter text.		

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the Krome North Service Processing Center (KNSPC), located in Miami, Florida, was conducted January 27-29, 2021 by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Sabina Kaplan and [redacted] for Creative Corrections, LLC. The audit period covered the previous eighteen months from July 2019 through January 2021. The Lead Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (b) (6), (b) (7)(C) and Assistant ICE PREA Manager, (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The ICE PREA Program Manager accompanied the Audit team and provided guidance during the on-site audit. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE External Review and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The incorporation date for the KNSPC was May 29, 2015. This was the second DHS PREA audit for KNSPC, and the audit review period included 18 months from July 2019 through January 2021.

The KNSPC is owned by U.S. Immigration and Customs Enforcement (ICE) and operated by Akima Global Services (AGS). The facility processes detainees who are pending immigration review or deportation. On the first day of the on-site audit, the facility held a total of 302 ICE adult male detainees. During the last 18 months, 13,236 adult male detainees were booked into the facility. The average time in custody is 78 days. The facility does not house juveniles or females, although females are processed through the facility intake area and the Bldg. 7 arrest in-processing area. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at KNSPC are from Mexico, Guatemala, and Honduras. The facility does not house juveniles, females, or family detainees. ICE Health Services Corps (IHSC) operates medical and mental health care at the facility. Akima Global Services (AGS) is contracted to provide security, transportation, and food service, referenced as facility staff. Native Energy is contracted to provide janitorial and maintenance services. Jesuit Religious Services (JRS) is contracted to provide religious services. This was the second PREA audit for the KNSPC, that followed a contingency audit process.

ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g. a health pandemic. The process is divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. During the Pre-Audit phase, the ERAU Team Lead contacts the facility to request submittal of facility documentation, completes a quality control review of the documentation, and uploads the documentation to SharePoint for the Auditor's review. As part of the initial document request, the Team Lead requests current rosters for detainees, staff, contractors, and volunteers, including any ICE staff assigned to the facility. Based on the size of the facility, the Auditor then selects the appropriate number of detainees, staff, volunteers, and contractors from the rosters to interview and supplemental documentation needed to confirm the facility's compliance with the PREA regulations. The second phase, Remote Interviews, consists of interviews (either through a virtual conference platform or conference line, the latter if the virtual platform is unavailable) with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers. The third phase, the On-site Audit, is not scheduled until the environment is safe for the ICE federal staff, facility staff, detainees, and Auditors. This phase mirrors a traditional PREA audit with a facility tour, observation of facility practices, and follow-up from the prior phases, as needed. Exit briefings occur at the end of Phase Two and Three, during which compliance issues identified and potential recommendations are discussed, if warranted. The facility's compliance was not fully determined until the completion of the on-site audit phase.

The Team Lead opened the entry briefing at 8:00 am on the first day of the on-site portion of the Audit. In attendance were:

- (b) (6), (b) (7)(C) Inspection and Compliance Specialist ICE/Office of Professional Responsibility (OPR)/ERAU
- (b) (6), (b) (7)(C) Inspection and Compliance Specialist, ICE/OPR/ERAU
- (b) (6), (b) (7)(C) ICE PREA Program Manager (PM), Creative Corrections, LLC
- (b) (6), (b) (7)(C) Detention Standards and Compliance Officer DSCO, ICE Headquarters
- (b) (6), (b) (7)(C) Commander, Eastern Regional Health Services, ICE/ ICE Health Services Corps (IHSC)
- (b) (6), (b) (7)(C) Officer in Charge (OIC) DHS/ICE
- (b) (6), (b) (7)(C) Captain, Assistant Health Services Administrator (AHSA), ICE/IHSC
- (b) (6), (b) (7)(C) Program Manager, Akima Global Services (AGS) /KNSPC
- (b) (6), (b) (7)(C) Lieutenant, Facility Health Program Manager, ICE/IHSC
- (b) (6), (b) (7)(C) Assistant Program Manager (APM), AGS/KNSPC
- (b) (6), (b) (7)(C) APM, KNSPC
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
- (b) (6), (b) (7)(C) Contracting Officer Representative, ICE
- (b) (6), (b) (7)(C) Investigator, AGS/KNSPC
- (b) (6), (b) (7)(C) Local Facility Chaplain, Jesuit Religious Services
- (b) (6), (b) (7)(C) Detention Officer (DO), ICE
- (b) (6), (b) (7)(C) DO, ICE
- (b) (6), (b) (7)(C) Certified DOJ/DHS Auditor, Creative Corrections, LLC

Brief introductions were made and the detailed schedule for the audit was covered. The Lead Auditor provided an overview of the on-site audit process and methodology used to demonstrate PREA compliance. The Lead Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures, but also, to ascertain whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Lead Auditor further explained compliance with the PREA standards will be determined based on the review of policy

and procedures, observations made during the facility tour, additional on-site documentation review, and conducting both staff and resident interviews. It was shared that no detainee correspondence was received.

During the on-site audit, the facility provided the requested information to schedule interviews for specific detainees who were LEP, filed a grievance regarding an incident of sexual abuse, and those who reported an incident of sexual abuse. The facility also provided, an updated PAQ, training records of randomly selected staff, and background documentation of randomly selected volunteers and contractors. The Lead Auditor informed the staff that she would like to observe the intake process and was able to do so on the first day of the on-site Audit. A facility tour was completed by the Audit team with key staff, which included the ERAU Team member, Assistant Program Managers, the PSA Compliance Manager, and various facility staff. All areas of the facility where detainees are afforded the opportunity to go or provided services were observed by the Audit team, including visitation, the intake in-processing area, the housing units, the medical services department, multi-purpose room, cafeteria, the law library, courtrooms, Krome Behavioral Housing Unit (KBHU), the Special Management Unit (SMU), the Building 7 arrest in-processing area, the laundry, barbershop, and other facility support areas. During the tour, the Auditors made visual observation of the program/service areas and housing unit including bathrooms, staff post sight lines, and camera locations. Sight lines were closely examined as were the potential for blind spots throughout the areas where detainees are housed or have accessibility. The Audit team spoke to random staff and residents regarding PREA education and facility practices during the tour. Review of the housing unit logbooks was conducted to verify staff rounds. All facility staff were very cooperative and informative during the audit process. The two-story administration building is comprised of a lobby and reception area, central control room, three court rooms, administrative and attorney offices, classrooms, mail room, staff gym, locker room, and serves as the pedestrian point of entry. The back portion of the administration building is located inside the secure perimeter of the facility and includes a medical area, visitation area, and the detainee in-processing area. As one exits the back of the administration building, it leads to an open campus style secure setting. There are four general population housing units, a special management unit, a transition housing unit, food service building, laundry, a multipurpose building used as a library and chapel area, and another building that contains administrative offices, including those of the Grievance Officer and Chaplain. In the center of the facility are recreation yards and a covered recreation area. (b) (7)(E) Cameras operate on a continuous loop allowing for approximately 30 days of viewing prior to recording over previous recordings unless saved to a disk. The cameras have the ability to zoom, but only a select few can tilt or pan. The video cameras are monitored in the Control Room and Processing Area by control room officers, ERO, and facility security staff. The Audit team carefully reviewed video camera footage and determined opposite gender staff could see into the bathroom areas where detainees would be in a state of undress. These areas included the holding cells dedicated to Pods 2, 3, and 6 in the visitation area; the out-processing changing room; the IHSC medical screening area holding cells; medical cells 1 and 2; the infirmary rooms 7, 9, and 10; the medical isolation rooms 3, 4, 5, and 6; patient rooms 1 and 4; the mental health rooms 1, and 4; and the cells in the Special Management Unit (SMU).

The Audit team observed opposite gender announcements were being completed upon entry into detainee housing units. PREA related information was posted in the housing areas throughout the facility. PREA educational and reporting information was posted on bulletin boards, and posted on walls, however, was not strategically located in certain areas, i.e. intake in-processing and the Special Management Unit (SMU) where it would be most visible to the detainees. Information available to them; PREA educational information, zero-tolerance policy, methods for reporting sexual misconduct, and victim advocacy contact information were posted in both English & Spanish, languages that are most prevalent. Auditors further observed through the review of staff logbooks that intermediate and high-level staff are making the required unannounced PREA rounds.

The remote interviews were divided between the Lead Auditor and the Second Auditor. The Second Auditor was assigned the responsibility of interviewing 33 detainees from the following categories: randomly selected detainees, disabled detainees, detainees who reported a sexual abuse history, detainees who reported sexual abuse, transgender detainees, and detainees with limited English proficiency (LEP) using the WebEx platform during the contingency process. During the on-site portion of the Audit, the Second Auditor interviewed 6 additional detainees from the following categories, detainees who reported sexual abuse (2), detainees with LEP (3), and a detainee who filed a grievance alleging sexual abuse (1) for a total of 39 detainees formally interviewed. The Auditor utilized the Language Services Associates language line provided through Creative Corrections to provide interpretation services for LEP detainees both during the contingency and on-site portions of the Audit. In addition, the Audit team informally interviewed seven random detainees regarding facility procedure. A total of 31 staff/contractors were formally interviewed during the contingency process using a conference line. Fourteen facility line staff were randomly selected from both shift rosters. Additionally, specialized staff were interviewed including the Officer in Charge (OIC), Prevention of Sexual Assault (PSA) Compliance Manager, five first line supervisors, two medical and mental health staff, Administration/Human Resources, two non-security contractors, two facility investigators (2), Training Supervisor, and intake staff (2). While on-site the Audit team informally interviewed an additional eight random and specialized staff regarding facility policy. Due to the pandemic, there was a lack of volunteers on site, and therefore, the Lead Auditor was only able to interview one volunteer during the contingency phase of the Audit. There were no available volunteers to interview during the on-site phase. Through the review of facility policy and procedures and interviews with detainees, intake staff, Facility Officer in Charge (OIC), and PSA Compliance Manager, provisions are not adequately made for the LEP detainees to receive written translation materials related to sexual abuse or assault in a language they understand for the facility's LEP detainee populations. Oral interpretation or assistance was not confirmed as being provided to any detainee who speaks another language in which written material has not been translated or who is illiterate. Detailed information regarding these services is outlined within the corresponding PREA standards noted throughout the report. Notices guaranteeing the privacy of PREA reporting hotlines were present in each housing unit. Detainees have access to phones in their living areas. Notices of the on-site audit were not posted throughout the facility, including the facility lobby area due to KNSPC not receiving the notices to post. They did post them during the on-site portion of the audit immediately upon receipt and were instructed to keep posted for two weeks. Notices were available in English and in Spanish. The Lead Auditor received no written communication from either detainee, staff, or third-party parties after the notices were posted.

The facility utilizes trained investigators to complete all allegations of sexual abuse. There were 29 sexual abuse allegations reported during the audit period: 21 cases involved detainee-on-detainee and 7 cases involved facility staff-on-detainee. All 29 cases were closed by ICE OPR. The Lead Auditor reviewed 16 sexual abuse allegations in total and found them to be very well-organized allowing for ease of auditing. All 16 investigations were referred to ICE OPR. None of the allegations reviewed were deemed criminal; and therefore, were not reported to the Miami-Dade Police Department. Of the 16 allegations reviewed, 7 cases involved facility staff on detainee. All cases were unsubstantiated. The remaining 9 cases involved detainee on detainee. Of the nine detainee-on-detainee cases seven cases were substantiated, and two cases were unsubstantiated.

On January 29, 2021, an exit briefing was held in the KNSPC staffing conference room. The Team Lead opened the briefing and then turned it over to the Auditor. In attendance were:

- (b) (6), (b) (7)(C) ICS ICE/OPR/ERAU
- (b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU
- (b) (6), (b) (7)(C) PM, Creative Corrections, LLC
- (b) (6), (b) (7)(C) DSCO, ICE Headquarters
- (b) (6), (b) (7)(C) Commander, Eastern Regional Health Services, ICE/IHSC
- (b) (6), (b) (7)(C) OIC DHS/ICE
- (b) (6), (b) (7)(C) Captain, AHSA, ICE/IHSC
- (b) (6), (b) (7)(C) APM, AGS KNSPC
- (b) (6), (b) (7)(C) APM, AGS KNSPC
- (b) (6), (b) (7)(C) SDDO, ICE/ERO
- (b) (6), (b) (7)(C) Captain, AGS KNSPC
- (b) (6), (b) (7)(C) Quality Assurance Manager (QAM), AGS KNSPC
- (b) (6), (b) (7)(C) Local Facility Chaplain, Jesuit Religious Services
- (b) (6), (b) (7)(C) DO, ICE
- (b) (6), (b) (7)(C) DO, ICE
- (b) (6), (b) (7)(C) DO, ICE
- (b) (6), (b) (7)(C) DO, ICE
- (b) (6), (b) (7)(C) Certified DOJ/DHS Auditor, Creative Corrections, LLC

The Auditor discussed observations made during the on-site portion of the audit and was able to give some preliminary findings, and further explained what would be entailed during the post on-site audit phase. The Auditors informed those in attendance they were appreciative of the hospitality received by facility staff, and for the professionalism provided by all staff during the visit.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

Number of Standards Met: 24
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.17 Hiring and promotion decisions
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.34 Specialized Training: Investigations
§115.35 Specialized training: Medical and mental health care
§115.43 Protective custody
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.86 Sexual abuse incident reviews
§115.201 Scope of audits.

Number of Standards Not Met: 16
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.51 Detainee reporting
§115.52 Grievances
§115.61 Staff and agency reporting duties
§115.67 Agency protection against retaliation
§115.77 Corrective action for contractors and volunteers
§115.81 Medical and mental health screenings; history of sexual abuse
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection

Number of Standards Not Applicable: 1
§115.14 Juvenile and family detainees

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. If additional space for notes is needed, please utilize space provided on the last page.

§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 facility has a written policy KRO/20.2.11 Sexual Abuse and Assault Prevention and Intervention (SAAPI) mandating zero-tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment. The policy provides definitions of sexual abuse and general PREA definitions. Through observation of bulletin boards, posters, educational handouts and materials, review of the facility's handbook (Detainee Handbook Local Supplement), and interviews with facility staff and detainees, it was apparent that the agency and the facility is committed to zero tolerance of sexual abuse. The zero-tolerance policy is publicly posted on the KNSPC website (www.ice.gov/detention-facility/krome-service-processing-center).

(d): The facility's Officer in Charge (OIC) appointed a PSA Compliance Manager at the supervisory level who oversees the facility's compliance efforts with the implementation of PREA. The Lead Auditor determined compliance through the review of the facility's policy KRO/20.2.11 (SAAPI) and an interview with the PSA Compliance Manager, who is also a center line supervisor. During the interview, the PSA Compliance Manager indicated he reports to the OIC, and AFOD, and confirmed he has sufficient time and authority to oversee facility efforts to comply with the sexual abuse prevention and intervention policy. Per policy KRO/20.2.11, the facility PSA Compliance Manager is responsible for overseeing that policies and procedures relative to the PREA are adhered to and ensure facility compliance, collecting and analyzing PREA data, assisting with the development of initial and ongoing training protocols, reviewing the results of every investigation of sexual abuse, and preparing required reports. The PSA Compliance Manager is the facility's point of contact to the agency's PSA Coordinator.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): A review of the PAQ indicated the facility's staffing level is 412 staff, 271 males and 141 females, which may have recurring contact with detainees. Line staff work two 12-hour shifts. Supervision of detainees was observed through on-site observations of line staff, intake staff, and medical staff supervising and interacting with detainees. The Lead Auditor reviewed daily shift rosters/assignments for all shifts and determined the facility is ensuring staffing levels are maintained in accordance with the standard. There are always line staff assigned to the housing unit who provide direct supervision of detainees. Video cameras operate 24-hours a day, 7 days a week. (b) (7)(E) [redacted] All cameras are stationary and have the ability to zoom. However, only a few designated cameras have the capacity to pan and tilt. Cameras are continuously monitored. Recorded video footage is available for review for up to 30 days. During an interview with the Building Facility Operations Manager, the Auditor was advised that video footage utilized during a PREA abuse investigation is downloaded onto a disk. It should be noted that although the backdoor to the laundry are was labeled, "Keep locked at all times," the door did not have the ability to be locked from inside the laundry area allowing unsupervised access to the unsupervised outside area by detainee workers.

(c): Meeting minutes supplied to the Lead Auditor in conjunction with the change from three shifts to two shifts in July of 2020 confirmed that, during the modification of on-site supervision, the facility did not take into consideration any judicial findings of inadequacy, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, or the findings and recommendations of sexual abuse incident review reports in evaluating whether the change in supervision will affect the facilitates efforts to prevent sexual abuse. The interview with the OIC further confirmed that the number of staff is determined by the physical plant layout, the size of the facility, and the composition of the detainee population.

Does Not Meet: Per subpart (c) of standard 115.13, "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, or the findings and recommendations of sexual abuse incident review reports, and any other relevant findings, including the length of time detainees spend in agency custody." Documentation submitted, in addition to the interview of the OIC, confirms that, during the last restructuring of line supervision, the facility did not take into consideration any judicial findings of inadequacy, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, or the findings and recommendations of sexual abuse incident review reports in evaluating whether the change in supervision would affect the facility's efforts to prevent sexual abuse. The facility must document that the standard elements of subpart (c) are taken into consideration during the review of supervision guidelines for compliance.

(b)(d): Policy KRO/20.2.4 Facility Security and Control and facility post orders outline the comprehensive detainee supervision guidelines to meet detainee supervision needs. Policy KRO/20.2.4 requires that "frequent unannounced security inspections shall be conducted on day and night shifts to deter sexual abuse of detainees and the shift supervisor shall visit each housing unit area and initial the log at least once per shift." It furthers states "the OIC, supervisors and others designated by the OIC shall visit the housing units once per week." The policy further dictates that "the facility shall prohibit staff from alerting others that these security inspections are occurring, unless such announcement is related to the legitimate operational functions of the facility." The post orders outline the responsibilities of detainee supervision including the requirement to make frequent but irregular patrols of the unit that are not regular and routine. The Second Auditor interviewed random facility line staff and reviewed housing unit logbooks on-site for unannounced rounds by supervisors and determined compliance. The Lead Auditor reviewed supervision guidelines (post orders) on-site and confirmed the annual formal review was conducted on the KNSPC Policies and Post Orders for 2020 as required by the 2011 Operation Manual ICE Performance Based Standards (PBNDS) in January 2020. The supervision guidelines (post orders) are approved by the OIC and distributed on an annual basis. During the review of (16) sexual abuse incident reviews, the PSA Compliance Manager reviewed the staffing supervision requirements. The Lead Auditor's review of the sexual abuse incident reviews indicated no staffing deficiencies.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)
Notes:

The KNSPC does not house juvenile and family detainees. Review of the PAQ and an interview with the PSA Compliance Manager confirmed the facility does not house juveniles nor family detainee units.

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

Outcome: Does not Meet Standard (requires corrective action)
Notes:

(b)(d): Policy KRO/20.2.10 Searches of Detainees states that "cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. All cross-gender pat-down searches shall be documented." Staff interviewed indicated that cross-gender pat-down searches are not conducted on the detainees at KNSPC. They further indicated that they had not conducted or were aware of any cross-gender pat-down searches conducted, during the audit period. This was further supported by a memo to file and the PAQ.

(c): KNSPC does not house female detainees for any length of time. Females that are processed through intake are held in the intake area until transferred. The policy KRO/20.2.10 states that "pat down searches of female detainees shall not be conducted unless exigent circumstances, and all cross-gender pat-down searches shall be documented." The Auditors toured the intake processing area, and interviewed intake staff, during the on-site portion of the audit. During the tour it was confirmed that when a female detainee is processed through KNSPC cross-gender viewing and searches do not occur. When a female detainee is processed, female facility staff perform the pat-down search, and the female detainee is housed separately from the other detainees. A privacy curtain is placed over the window of the intake cell door to afford privacy from cross-gender viewing during the stay. Staff further indicated that if a female detainee is processed in the Building 7 arrest in-processing area a privacy curtain would be brought to that area to guarantee no cross-gender viewing by male staff.

Recommendation: The facility should maintain a supply of the female privacy curtains in the building 7 arrest in-processing center for immediate access by staff.

(e)(f): Policy KRO/20.2.10 states that "an officer of the same gender as the detainee shall not perform a strip search except in the case of an emergency. All strip searches or cross-gender searches shall be documented." KR/20.2.10 further states that "a body-cavity search must be performed by a medical professional, upon the approval of the OIC, and must take place in an area that affords privacy." Interviews with line staff confirmed they are aware of the facility policy for conducting strip or body-cavity searches, and if performed shall be approved by a supervisor and documented by incident reports. During the audit period, no cross-gender strip or body-cavity searches were conducted. This was documented through a memo to file and interviews with medical and facility supervision staff.

(g): The facility's policy 20.030 Personal Hygiene states that "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." Policy 20.030 also states "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." Interviews with detainees, and facility staff, also confirmed the detainees have privacy for these functions. During the interviews, female facility staff indicated they announce themselves when entering an area by announcing "female on deck." Detainees interviewed stated they did recall opposite gender staff announcing themselves on a regular basis. During the on-site portion of the tour the Auditors observed female facility staff announcing themselves as required by policy. However, during the on-site portion of the audit, the Auditors observed the following opposite gender viewing issues throughout the facility: the holding cells dedicated to Pods 2, 3, and 6 in the visitation area had toilets visible to staff of the opposite gender; the out-processing changing room was visible on the control center camera and a female was staffed in the area; the IHSC medical screening area holding cells toilets could be viewed by the opposite gender staff; medical cells 1 and 2 toilets could be viewed by opposite gender staff; the infirmary rooms 7, 9, and 10 and the medical isolation rooms 3, 4, 5, and 6 toilets and showers could be viewed by the opposite gender staff and were also visible on camera by opposite gender staff; patient rooms 1 and 4 had toilet cell toilets could be viewed by opposite gender staff; the mental health rooms 1, and 4 toilets could be viewed by opposite gender staff and were also visible on camera by opposite gender staff; and the cells in the SMU had changing viewing issues as they were visible on camera by opposite gender staff. In addition, the detainee bathroom in the Krome Behavioral Health Unit (KBHU) was not secured, or controlled by facility staff, allowing the detainees to enter at will and the handicapped shower could be viewed by opposite-gender staff. Building 8 housing unit had similar opposite gender viewing issues, however, the facility provided the Lead Auditor with a shift roster, on-site, confirming the area was supervised by male-only posts.

Does Not Meet: (b) (7)(E) [redacted]

(i): ICE Best Practices for Cross-Gender, Transgender, and Intersex Searches states "that all searches be conducted in a professional and respectful manner, consistent with security needs." Interviews with the Training Supervisor and facility staff, the review of the training lesson plans reinforcing these policies in the annual training, and the review of facility staff training records confirmed that training is conducted as required by the standard. Policy KRO/20.2.10 states that "KNSPC shall not search or physically exam a detainee for the sole purpose of determining a detainee's genital characteristics." It further states that "if a detainee's gender is unknown, it may be determined during conversation with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other in-processing procedure conducted in private, by a medical practitioner." No pat-down searches for the sole purpose of determining a detainee's genital status have occurred in the audit period per documentation memo and interviews with facility line and medical staff.

§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): Policy KRO/20.2.11 (SAAPI) dictates that "the detainee PREA notification, orientation, and instruction be in a language or manner 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, therefore guaranteeing that detainees with disabilities and detainees with limited English proficiency (LEP) have an opportunity to participate in and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment." Upon intake, detainees, as required by KRO/20.2.11, are to be provided with the ICE National Detainee Handbook, available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese) and the facility's Detainee Handbook Local Supplement to the ICE National Detainee Handbook, available in English, Spanish and Creole only. Both handbooks provide detainees with information on the agency and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse, as well as information on residents' rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS. The medical staff advised if a detainee coming through intake spoke a language that was not available in a written format, they would utilize an interpretive service, Lionbridge. The Intake Supervisor interviewed stated the detainees are provided written materials in a language they understand through the handbooks, and the language line, U.S. Citizenship, and Immigration Services (USCIS), when needed for interpretation. In the 16 allegation investigations reviewed; the Lead Auditor determined the facility used facility staff interpreters and did not utilize another resident to interpret during the investigations. The Audit team also reviewed 10 detainee A-files and 12 detainee detention files and although the files contained a preferred language form, all the preferred language forms submitted with the files were incomplete and did not clearly indicate how language assistance was provided to the detainee. In addition, the documentation reviewed in all 22 detainee files was unclear as to what handbook the detainee received, ICE or facility, nor was it clear from the documentation what language handbook(s) was given to the detainee. Interviews with detainees housed at KNSPC during the remote interview phase, and during the on-site portion of the audit who were LEP indicated they rely heavily on other detainees to understand what is being stated by facility staff. In addition, the review of 12 detainee detention files during the on-site portion of the Audit, confirmed that detainees who spoke languages other than English or Spanish consistently were documented of wanting the English facility's Detainee Handbook Local Supplement by choice. There was no documentation to confirm the detainees received the additional ICE National Detainee Handbook in their preferred language. Interviews with facility staff confirmed there is an available language line, however, none of the interviewees, with the exception of the supervisor of the intake area, were clear as to how the language line was used.

During the on-site portion of the audit, the Audit team observed the in-processing of a detainee. The detainee was Spanish speaking and a Spanish speaking facility staff provided interpretation; however, it was noted by the Auditors that the preferred language form was filled out prior to the detainee being in-processed. In addition, the detainee was not provided with the ICE National Detainee Handbook. The detainee received the facility's Detainee Handbook Local Supplement; however, the facility staff member did not cover the PREA information with the detainee. The Audit team further observed, during the facility tour, that there was only one available phone that was dedicated as the language line. Upon discussing, with the intake area line supervisor, what would happen if they received their average intake of 50 detainees and there was an overwhelming need to provide language line services, the intake area line supervisor was not clear as to how this service would be provided to more than one detainee. In addition to the detainees who indicated that they did not receive a copy of the facility's Detainee Handbook Local Supplement during the contingency phase of the audit, the Audit team informally interviewed seven random detainees regarding whether or not they received the ICE National Detainee Handbook. Only one of the detainees interviewed indicated that he had received the ICE National Detainee Handbook; this detainee was English speaking. In addition, the facility did not provide the Auditors during the remote interview phase, or during the on-site portion of the audit with clarification regarding how a detainee with a disability, such as blindness or deafness, is aided in understanding the PREA information provided at intake. During the on-site portion of the audit, the Audit team observed the orientation video that is played at intake processing. The video is closed-captioned; however, the volume was extremely low making it difficult for the visually impaired to receive and understand the information.

Does Not Meet: The Audit team observed the in-processing of a Spanish speaking detainee, who was provided with interpretation services through a facility staff member during intake, however the form documenting interpretation services was filled out prior to the detainee actual arriving and confirming his language preference upon arrival. In addition, the detainee was not provided the ICE National Detainee Handbook which contains important PREA information for LEP detainees who do not understand the languages the facility's Detainee Handbook Local Supplement is available in. The facility's Detainee Handbook Local Supplement is only available in English, Spanish, or Creole. Informal interviews with random detainees confirmed that they did not receive the ICE National Detainee Handbook. In addition, interviews with facility staff did not confirm whether each LEP detainee is provided the proper interpretation services needed through the language line nor did they confirm whether LEP detainees would receive both the ICE National Detainee Handbook and the facility's Detainee Handbook Local Supplement upon intake. For compliance, the facility must demonstrate how LEP detainees are provided the PREA information in a manner they understand, and all detainees receive an ICE National Detainee Handbook in a language they understand, if available, or document how the information is provided to them through another method. The facility must provide 10 LEP detainee files documenting that the PREA information was provided to the detainee in a manner they understand. The documentation must demonstrate a variety of languages, other than English and Spanish over a month period.

§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): Through review of Executive Order 10450 Security Requirements for Government Employment and the Office of Personnel Management Section Part 731 Suitability; and ICE Policy system Directive Title ICE Personnel Security and Suitability Program, it was determined the agency has established a system of conducting criminal background checks for new employees, contractors, and volunteers who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement setting; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in such activity. Department of Homeland Security 6 Code of Federal Regulations Part 115 (Standards to Prevent, Detect, and Respond in Sexual Abuse and Assault Confinement Facilities) form contains a statement indicating that applicant responses are true and correct to the best of his/her knowledge. If the applicant knowingly and willfully gives a false response it may result in a negative finding regarding falsifying or omitting information, and he/she will be rejected from the selection process. The Human Resource staff person interviewed confirmed the wording on the application and that a person would not be hired or would be terminated for falsifying information. During the review of the four facility staff personnel files, the wording was verified on the facility staff application forms. The standard addresses the utilization of this process in the promotional system. After reviewing the above policies, and interviewing the OIC, the Lead Auditor confirmed that if a facility staff person was involved in any misconduct of this nature, they would not be employed or contracted by ICE. Employees also have a continuing affirmative duty to report misconduct. The Human Resource Manager stated staff are required to report any misconduct to their supervisor who is responsible to make a report to the AFOD. The AFOD is then responsible to report to the Joint Intake Center (JIC) managed by ICE. This requirement

is shared with facility staff in the initial and refresher PREA training. If the agency receives an arrest notification, the notification will be forwarded to the OPR Investigation Unit and Labor Relations.

(c)/(d): During a training session on September 25, 2018 and the training documentation available on SharePoint, the OPR Personnel Security Unit (PSU) Assistant Deputy Division Director explained that all ICE staff and any ICE contract employees must clear a background investigation through PSU before hiring or promoting any staff or contractor who may have contact with detainees. The contractor or staff complete an Electronic Questionnaire for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE. If it is a contract employee, the office informs the contractor the employee cannot perform work on behalf of ICE. The PSU Assistant Deputy Division Director explained the sexual misconduct questions are asked of the potential employee as part of the e-QIP. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a supervisor. For this facility, ICE PSU conducts background checks on ICE employees. The Auditor submitted six ICE employee names to PSU to verify the background check process. All were compliant. Documentation also confirmed the due dates for the five- year background rechecks. A review of four facility staff files confirmed background checks were completed and resubmitted as required by the standard. A review of three contractor files on-site confirmed that all but one contractor had received a background check prior to entering the facility. According to the facility, the third contractor had received a background check, however, her file could not be located. A review of five volunteer files confirmed that background checks were conducted on volunteers and that National Crime Information Center (NCIC) clearance was required, however due to a lack of dates on the provided background check responses it was difficult for the Auditors to determine exactly when the background checks were completed.

Recommendation: The facility should develop a process to document to include record keeping procedures to reflect if/when background checks are conducted on contractors assigned to the facility who deliver specific services and have detainee contact.

(e): ICE Directive 6.8 ICE Suitability Screening Requirements for Contractor Personnel and 5 CFR 731 states that the agency will make an unsuitability determination if the contractor or employee provides a material, intentional false statement or deception, or fraud in examination or appointment. The interview of the OIC confirmed that KNSPC would not hire a contractor or employee that provided a material, intentional false statement, or deception or fraud in examination or appointment.

(f): Executive Order 10450 Security Requirements for Government Employment states, "The appointment of each civilian officer or employee in any department or agency of the Government shall be made subject to investigation. The scope of the investigation shall be determined in the first instance according to the degree of adverse effect the occupant of the position sought to be filled could bring about, by virtue of the nature of the position, on the national security, but in no event shall the investigation include less than a national agency check (including a check of the fingerprint files of the Federal Bureau of Investigation), and written inquiries to appropriate local law-enforcement agencies, former employers and supervisors…" During the Lead Auditor's interview with the Human Resources Coordinator it was determined that staff are hired through an extensive review and investigation by ICE. The interview with the AFOD confirmed that any incident is reported to the JIC managed by ICE.

§115.18 - Upgrades to facilities and technologies.

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

(a)(b): Facility policy KRO/20.2.11 (SAAPI) states that "when designing or acquiring any new facility and in planning any substantial expansion or modification of the existing facilities, the facility shall consider the effect of the design, acquisition, expansion, or modification upon their ability to protect detainees from sexual abuse." Policy KR/20.2.11 (SAAPI) further states that "when installing or updating video monitoring system, electronic surveillance system or other monitoring technology in a facility, the facility shall consider how such technology may enhance their ability to protect detainees from sexual abuse." The facility was constructed in 2001. Since their last DHS PREA audit on July 28, 2017, the facility expanded their SMU from 7 cells to 25 cells which included additional showers, dayrooms, and recreational areas. During the design of the expansion to this facility, the KNSPC administration considered the ability to protect detainees from sexual abuse. The placement of security cameras and video monitoring was assessed upon the completion of the SMU and all PREA standards were considered. An interview with the OIC confirmed these changes. A review of a written memo from the previous facility's PSA Compliance Manager and the Lead Auditor's interview with the OIC confirms the addition of PREA enhancements since KNSPC's last PREA audit.

§115.21 - Evidence protocols and forensic medical examinations.

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

(a): Facility Policy KRO/20.2.11 (SAAPI) outlines to the extent the agency or facility is responsible for investigating allegations of sexual abuse involving detainees and follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. KRO/20.2.11 dictates that "where evidentiary or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the OIC shall arrange for an alleged victim to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensics Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable." SAFE/SANE exams are performed at the Jackson Memorial Hospital. Per policy, "if SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable." The Lead Auditor was able to corroborate through an interview with the PSA Compliance Manager, that evidence protocols are developed in coordination with DHS. The Lead Auditor's interviews with random facility line staff and IHSC staff confirmed they are aware of the facility's evidence protocols and know what necessary steps to take during a report of sexual abuse.

(b)(d): During the on-site portion of the audit, the Auditors observed signage advising the detainee population they have access to Roxcy Bolton Rape Treatment Center; however, the facility did not provide a signed Memorandum of Understanding (MOU) to confirm that Roxcy Bolton will provide victim advocacy services to victims of sexual abuse/assault. Email correspondence provided on-site documented the facilities efforts to enter into said MOU and Roxcy Bolton's agreement to provide victim advocacy services to all victims of sexual abuse at the hospital during a forensic exam and/or during an investigatory interview. The Second Auditor reached out to the Roxcy Bolton representative working with the facility to secure the MOU, but the representative did not respond to her inquiry. The facility reported 29 abuse investigations during the audit period. All cases were investigated and closed by ICE OPR. The Lead Auditor's review of 16 sexual abuse investigation files confirmed that victim advocacy services were offered to the detainees and recorded in the PREA Summary Investigation Report and the PREA Checklist. Of the four detainees interviewed by the Second Auditor who reported sexual abuse, two stated they were not offered victim advocacy services at the time of their reporting of the allegation. Both detainees

indicated they wanted the facility to refer them for services. Their names were submitted to the facility for follow-up. An email provided by the facility indicated that they would provide both detainees with a copy of the flyer given to all victims of sexual abuse indicating the availability of the advocacy services.

Recommendation: The facility should continue to pursue an agreement/MOU with the Roxcy Bolton Rape Treatment Center to outline services agreed upon by both agencies.

(c): Interviews with facility medical staff acknowledged victims of sexual abuse would undergo a forensic medical exam at no cost to the detainee and only with consent of the detainee. On the PAQ, the facility indicated that Jackson Memorial Hospital is where detainees would receive treatment and/or forensic sexual assault medical exams. The facility has made attempts to enter into an MOU with Jackson Memorial Hospital which would outline the forensic services to be provided if a detainee required a forensic examination, however, at the time of the on-site audit the facility had not secured a signed agreement /MOU. Medical staff interviewed by the Lead Auditor indicated they would take the detainee to Jackson Memorial Hospital for a SANE exam. During the on-site portion of the audit, the Second Auditor was able to reach out, via telephone, to the medical staff at Jackson Memorial Hospital and confirmed that they would provide SANE nurses upon request of the facility. A review of 16 completed investigations and an interview with the medical staff indicated the facility has not needed to send out a detainee for a forensic medical exam during the audit period. However, a review of a detainee's mental health record indicated that one detainee requested a forensic exam due to his belief that he was raped the night before; however, there was no record of the detainee being sent to Jackson Memorial Hospital. The review investigative files do note, however, the detainee's mental health status and that he was provided mental health support as needed.

Recommendation: The facility should develop an agreement/MOU with the Jackson Memorial Hospital to outline services agreed upon by both agencies.

(e): Policy KRO/20.2.11 (SAAPI) outlines the responsibilities of the Investigating Entity/Forensic Medical Exams Investigations conducted by a facility employee for forensic medical examinations. "In the event the investigation is being conducted by a non-federal investigating agency, the facility shall request that the investigating agency follow applicable requirements of this standard." The Lead Auditor was provided with a memo from the former facility PREA PSA Compliance Manager that stated the Miami-Dade County Police Department will not enter into an MOU as they are required to respond if needed based on KNSPC being a federally owned facility in their local jurisdiction. The memo further stated that KNSPC would attempt to ensure that Miami-Dade Police Department follow the protocols under this section.

§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): Policy KRO/20.2.11 dictates the procedures for investigation of allegations and appropriate agency oversight, including coordinating with ICE and other appropriate investigative agencies to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and procedures for coordination of internal administrative investigations with the assigned criminal investigative entity to ensure non-interference with criminal investigations, as well as coordination with the ICE Office of Professional Responsibility (OPR). In addition, Policy KRO/20.2.11 dictates that "the facility shall retain reports of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five years." Interviews with the OIC, PSA Compliance Manager, and facility investigators corroborated the above-mentioned policy. The policy further states, "that if a detainee alleges sexual assault, KNSPC shall coordinate with ICE and other appropriate investigative agencies to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators and 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. Administrative investigations shall be conducted after consultation with the appropriate investigative office within ICE/DHS, and the assigned criminal investigative entity." It should be noted the Auditor reviewed on the agency's website, the ICE policy, and procedures to ensure that each allegation of sexual abuse is investigated by the agency or the facility or referred to an appropriate investigative authority. "Administrative investigations will include preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviewing alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator." The PREA allegation spreadsheet reported 29 allegations of sexual misconduct. All 29 cases were investigated and closed. The Auditor reviewed 16 of the reported allegations in their entirety and found them to be organized allowing for ease of auditing. The Auditor further determined the 16 reviewed investigations were compliant with the PREA standards in all material ways. All cases were referred to ICE OPR. Of the 16 cases reviewed by the Lead Auditor, zero investigations were referred to the Miami-Dade Police Department; and therefore, there were zero cases referred for prosecution.

(c): A review of the ICE website (https://www.ice.gov/prea) confirms the sexual abuse investigation protocols are available to the public. A review of the facility website (www.ice.gov/detention-facility/krome-service-processing.center) confirms the protocols are available to the public.

(d)(e)(f): Policy KRO/20.2.11 outlines the facility's protocol which ensures that "all allegations are promptly reported to the agency, and, unless the allegation does not involve potentially criminal behavior, are promptly referred for investigation to an appropriate law enforcement agency with the legal authority to conduct criminal investigations. The Auditor reviewed 16 sexual abuse investigations and determined the investigations were completed timely and the proper notifications were made in accordance with the standard. Interviews with the OIC, PSA Compliance Manager, and facility investigator indicated all allegations are promptly reported to the JIC, the ICE OPR, or the DHS Office of Inspector General (OIG), as well as the appropriate ICE Field Office Director (FOD).

§115.31 - Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy KRO/20.2.11 outlines how the facility trains all employees who may have contact with detainees, and for all facility staff to be able to fulfill their responsibilities and includes each element of the standard. The policy dictates that "training on the facility's SAAPI Program shall be included in training for all new employees and shall also be included in annual refresher/in-service training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards." The Auditor reviewed the KNSPC PREA training curriculum and determined it to be compliant with the standard in all material ways. The Auditor randomly selected six facility staff files and reviewed training documentation for proof of completion and determined the training was compliant per the standard's requirement, to include by the facility's PREA incorporation date. Staff training

documentation is maintained within employee training files. Interviews with the Training Supervisor confirmed the facility staff have received the required PREA training and refresher training. Facility staff receive the same level of PREA comprehensive training annually, exceeding the requirement of the standard, which calls for refresher training every two years. However, the Lead Auditor further reviewed the training files of five ICE staff, who have contact with detainees, and four of the training files confirmed that PREA training was not provided in accordance with the standard. Two ICE staff members had not received PREA training since 2016 and 2018 respectively, and two ICE staff members had not received PREA training at any time.

Does Not Meet: The Lead Auditor reviewed five training files of ICE staff who have contact with detainees and confirmed that four of the five files reviewed were not compliant with the standard, that requires "the agency to train or require the training of all employees who may have contact with detainees, and all facility staff, to be able to fulfill their responsibilities under this part." For compliance all ICE staff who have contact with detainees must receive PREA training and the training documented by the facility. The Auditor will select and request five ICE staff training files for compliance review.

§115.32 - Other training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy KRO/20.2.11 outlines how "the facility shall train, or require the training of, all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard. Per the policy, KNSPC will ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures." The policy further states that "the level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed on how to report such incidents." In review of the training curriculum, the Auditor determined all the required elements of the standard are covered and the curriculum meets the level and type of training required for volunteers who may have contact with detainees. Submitted with the facility PAQ was supporting documentation of completed training for volunteers, including signed acknowledgments of training received and training session sign-in sheets. The Lead Auditor interviewed the facility's Chaplain, who is responsible for conducting volunteer training and the Second Auditor reviewed five volunteer training records on-site and determined all volunteers received the required training. In addition, while on-site, the Lead Auditor reviewed three training files for contractors, who provide services at KNSPC and have contact with detainees. The Auditor's review confirmed that none of the contractors received PREA training. The Lead Auditor further interviewed the Assistant Program Manager (APM), responsible for contractors, who confirmed that the contractors had not received the training as required by the standard and that there was no procedure in place to provide the training.

Does Not Meet: The Lead Auditor reviewed three contractor files who have contact with detainees and interviewed the Assistant Program Manager responsible for contractors and confirmed that KNSPC does not have a procedure in place to train contractors who provide services to KNSPC and have contact with detainees, as required by the standard. For compliance the facility must complete and document PREA training for all contractors. The facility must submit a list of contractors to the Auditor to select five random training files for compliance.

§115.33 – Detainee Education

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(c)(e)(f): Policy KRO/20.2.11 indicates that "following the intake process, KNSPC shall provide instruction to detainees on the KNSPC's SAAPI Program and ensure that the instruction includes KNSPC's zero-tolerance policy for all forms of sexual abuse." Documentation submitted with the PAQ indicates that PREA information was provided to detainees through the DHS-prescribed Sexual Assault Awareness Information pamphlet, DHS posted signage "ICE Zero-Tolerance", the ICE National Detainee Handbook, and the local facility's Detainee Handbook Local Supplement to the ICE National Detainee Handbook. The Audit team reviewed Detainee Summary Forms contained in 10 detainee Alien files (A-files) and 12 detainee's detention files, which were signed by the detainees, indicating that they had a question-and-answer session conducted with them concerning the handbooks, DHS-prescribed Sexual Assault Awareness Information pamphlet, and an orientation video. However, during the on-site portion of the audit, the Audit team observed the intake processing of a detainee that, although the facility staff had the detainee sign this section of the Detainee Language and Communication Assistance form, the detainee was not advised of any of the above. The Audit team observed the facility staff person simply hand the detainee a facility's Detainee Handbook Local Supplement. The detainee was then told to sit in a holding cell, where the orientation video was playing above him, in a language he did not understand, with the sound inaudible. The Audit team also observed another detainee in a holding cell, who was told to sit under the tv playing the orientation video; however the sound inaudible. When the Audit team requested that the video be played at an audible level, facility staff had difficulty finding the remote control to turn up the volume. In addition, the detainee remained in the holding tank for a minimal period of time, which did not allow him to view the orientation video in its entirety. Further, upon observation in the other holding cells, the Audit team determined the sound was inaudible in all the cells. The detainee observed during the intake process was not given a DHS-prescribed Sexual Assault Awareness Information pamphlet; intake staff indicated that it was incorporated into the facility's Detainee Handbook Local Supplement, however, he was not advised that the PREA information existed in the handbook or where he could find it. In addition, the detainee was not supplied with a copy of the ICE National Detainee Handbook. During the Auditors review of the 22 detainee files, there was a detainee signed receipt of a handbook(s), however the files were illegible in determining which handbook(s) the detainee actually signed that was received. Although the Detainee Language and Communication Assistance form, provides a way to document the assistance for LEP detainees, of the 12 detainee files and 10 detainee A-files reviewed by the Lead Auditor, none of the Detainee Language and Communication Assistance forms were properly filled out; and therefore, cannot be used to determine standard compliance.

Does Not Meet: The Lead Auditor, through both interviews and on-site observation determined that the PREA information is not provided to detainees as required by subparts (a, c, and e, and f) of the standard. Although the facility has the detainee sign a Detainee Summary Form as required by subpart (c) of the standard, the form does not reflect what actually occurs during the intake process. While observing a detainee's intake processing, the Audit team confirmed that facility staff did not provide or discuss PREA information including zero-tolerance policy, provide the detainee with the ICE National Detainee Handbook, inform the detainee of PREA information including that the DHS-prescribed Sexual Assault Awareness Information pamphlet was int the facility's Detainee Handbook Local Supplement, and did not provide the detainee an opportunity to view the Spanish Orientation Video which included PREA information at any time during the intake process. The detainee, by virtue of receiving the local facility's Detainee Handbook Local Supplement, received a copy of the DHS-prescribed Sexual Assault Awareness Information pamphlet The facility must ensure that detainees are informed about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse that addresses standard elements in (a) and document the process properly. The PREA orientation must be provided in a language or manner the detainee understands and documented to

demonstrate compliance. The Auditor will request intake lists from various days to select random detainee to review their files for compliance on the PREA education orientation process.

Recommendations: In addition, although the facility has the zero-tolerance signage in the dayroom of the SMU, not all detainees utilize this area, therefore it is recommended that the zero tolerance posters which include the name of the PREA Compliance Manager, are displayed in the SMU hallway providing the opportunity for all detainees assigned to that unit accessibility to the information. In addition, the Lead Auditor recommends that the facility update the PREA Zero tolerance poster located in the Building 7 arrest in-processing area to the most recent publication to include the current name and phone number of the facility's PSA Compliance Manager and place PREA signage in the in-processing area multi-detainee holding cells.

(b) Policy KRO/20.2.11 states detainee orientation and instruction must be in a language, or manner that the detainee understands, including for those who are LEP, deaf, visually impaired, otherwise disabled, as well as to detainees who have limited reading skills. The ICE National Detainee Handbook is available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). Of the 39 detainees interviewed by the Second Auditor, only a few detainees were aware of the zero-tolerance policy at KNSPC and most detainees were unfamiliar with the subject of PREA in general. During the on-site portion of the Audit, the Lead Auditor was advised by the Intake Supervisor that while the facility's Detainee Handbook Local Supplement was available in English, Spanish, and Creole only, detainees receive an ICE National Detainee Handbook in their language of choice to supplement the facility's Detainee Handbook Local Supplement. During the on-site tour the Audit team confirmed, through observation of an intake processing, that not all detainees receive an ICE National Detainee Handbook or one in a language they understand. The Audit team, through on-site observation, confirmed that the orientation video is closed caption, however, it is only available in English, Spanish, and Creole. During the on-site portion of the Audit, the Audit team, through interviews with intake processing facility staff could not confirm how the facility provides the PREA education to those detainees who are LEP and speak another language not covered by the orientation video, deaf, visibly impaired, or otherwise disabled.

Does Not Meet: During the on-site portion of the Audit, the Audit team observed the intake processing of a detainee. By observing this process, the Audit team confirmed that the facility does not meet subpart (b) of the standard. The detainee was not afforded the opportunity to watch the orientation video in his preferred language, Spanish, nor was he provided with an ICE Detainee National Handbook in Spanish. Although the video was closed captioned, in an interview with the Intake Supervisor, the Lead Auditor was not provided a clear policy regarding how the facility would provide this information to a detainee who was visually impaired or otherwise disabled, who had limited reading skills, or who spoke a language other than English, Spanish, or Creole. The facility must ensure detainees are provided an orientation program in a language or manner the detainee understands and informs the detainee about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse and addresses each standard element in (a). This facility must document the orientation process of each detainee. The Auditor will request a detainee intake list from various days to select random LEP detainees and detainees with disabilities to review the detainee files for the PREA orientation process in a manner the detainee understands for standard compliance.

(d) During the on-site portion of the Audit, the Audit team observed the posting of related PREA informational signage and the location of said signage, the DHS-prescribed sexual assault awareness notice, and the posting of the name of the current PSA Compliance Manager. There is also contact information for the local rape crisis center that can assist detainees who have been victims of sexual abuse.

Recommendation: Although the facility has the zero-tolerance signage in the dayroom of the SMU, not all detainees utilize this area, therefore it is recommended that the zero-tolerance posters, which include the name of the PREA Compliance Manager, are displayed in the SMU hallway so that all detainees assigned to that unit are aware of its presence and the information it provides. In addition, the Lead Auditor recommends that the facility update the PREA Zero-tolerance poster located in the Building 7 arrest in-processing area to the most recent publication, to include the current name and phone number of the facility's PSA Compliance Manager, and place PREA signage in the in-processing area multi-detainee holding cells.

§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): Policy KRO/20.2.11 states that "all investigations into alleged sexual assault must be conducted by specially trained, qualified investigators and mandates that the training cover interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigative process." The training curriculum, PREA Investigator Training for Inmate Allegations of Sexual Abuse, was provided on-site through the Public Agency Training Council in 2018. This training covered understanding the unique nature of investigating sexual abuse in confinement, the techniques for interviewing sexual abuse victims, the proper uses of Miranda and Garrity warnings, the proper techniques for the collection of physical evidence, understanding best practices for reaching investigative conclusions, and describing the level of evidence needed to substantiate both administrative and criminal findings. Interviews with the OIC, facility investigators, PSA Compliance Manager, and Training Supervisor indicated that the facility investigators have received specialized training for conducting sexual abuse investigations in accordance with the standard. KNSPC has two investigative staff and both have received specialized training for conducting sexual abuse investigations. The Auditor was provided with certificates of completion for both investigators. The Auditor determined the curriculum meets the standard requirements in all material ways. Staff interviews verify the training was completed, and they are knowledgeable of the requirements needed to conduct sexual abuse investigations within a confinement setting. The Auditor also confirmed through the review of ICE Headquarter documentation list of specialized trained investigators that the appropriate training was completed by the facility's ICE investigative staff. KNSPC reported 29 incidents of sexual abuse during the audit period. In review of 16 investigation files the Lead Auditor determined they were all completed by specially trained investigators.

§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)(c): Health care is provided to detainees through IHSC medical staff. IHSC Directive 03-01 requires all IHSC staff to receive training on the agency directive SAAPI, PREA standards, and response protocol. The training is required during initial orientation and annually thereafter. The training includes how to detect and assess signs of sexual abuse, professional and effective response to victims of sexual abuse, reporting procedures, evidence preservation, and effective communication with Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) or gender nonconforming detainees. The Lead Auditor reviewed five medical staff training files on-site and confirmed that the IHSC staff received the specialized training as required by the

standard. However, the files further confirmed that the training was not always received during initial orientation, nor is it delivered annually as required by IHSC Directive 03-01.

Recommendation: The IHSC staff should receive the required training during initial orientation, and then annually thereafter, as required by IHSC Directive 03-01.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): Policy KRO/20.2.11 states that "KNSPC 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 policy further states that "each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly and that the screening shall consider 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 been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as LGBTI or gender nonconforming, whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as having previously experienced sexual victimization, and the detainee's own concerns about his or her physical safety." According to interviews with the Classification Supervisor and intake staff, ICE screens detainees for special vulnerabilities prior to being transferred into the facility, which is reflected on a Risk Classification Assessment (RCA) screening form. The RCA screening takes into consideration whether the detainee has a mental, physical or developmental disability, the age of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as LGBTI or gender nonconforming, whether the detainee has any convictions for sex offenses against an adult or child, 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 RCA further considers prior convictions for violent offenses and institutional history but does not consider any prior convictions for sexual abuse. This information, along with the physical appearance of the detainee, is captured when the detainee is interviewed by medical and entered through the IHSC Intake Screening; however, it does not appear that the information is utilized in making an initial housing determination. During the contingency portion of the audit, the Lead Auditor reviewed 10 detainee A-files and determined the files lacked the completed documentation needed to meet the standard. While on site, the Audit team reviewed an additional 12 detainee files. Included in the 12 detainee files, but not the 10 A-files reviewed, was an "In-Processing Special Vulnerability Questionnaire" that according to the Intake supervisor, was developed by the facility and is used to gather detainee information upon intake. The form includes whether the detainee has a mental, physical or developmental disability, the age of the detainee, whether the detainee has self-identified as LGBTI 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 form does not take into consideration the physical build and appearance of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, or whether the detainee has any convictions for sex offenses against an adult or child. The facility's Policy KRO/20.2.2 dictates that "the initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility." Intake staff were interviewed and confirmed the timeline for in-processing new detainees. Documentation submitted with the PAQ confirmed that not all detainees are screened upon intake. The review of a sexual abuse investigation file determined that the two involved detainees were not screened upon their arrival to KNSPC. When the facility could not provide the two detainees' intake files, they advised the Lead Auditor that they did not conduct any intake processing on either of the two detainees. In addition, of the 33 detainees interviewed, only four detainees could clearly articulate they had been screened when they arrived at KNSPC.

Does Not Meet: The Lead Auditor, reviewed a sexual abuse investigation file and determined that both the victim and the abuser were not screened upon arrival to KNSP. The facility advised the Lead Auditor that the two detainees were not assigned to KNSPC. The staff indicated that the two detainees were being held over from another detention facility, due to impending bad weather, and therefore, were not afforded intake screening. The facility must assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and utilize this information for housing determinations to prevent sexual abuse for compliance. The Auditor will request a detainee intake list from various days to select random detainees to review the detainee's risk screening was completed within 12 hours to ensure all detainees arriving at the facility have a completed risk screening.

(e): According to the Lead Auditor's interview with the Classification Supervisor, reassessment of a detainee's risk level for victimization or abusiveness is conducted by the appropriate case manager. The RCA module is also used for completing the reassessment. During the review of 10 detainee A-files and 12 detainee detention files, the Audit team found that none of the files confirmed the proper procedures are being followed per the standard. Both sets of files were incomplete and did not provide the Lead Auditor with the documentation to confirm that detainees are reassessed as mandated by the standard. Issues involving completing the reassessment during the required 60 and 90 days, in addition to not reassessing detainees following an incident of abuse or victimization was confirmed. An interview by the Lead Auditor with the APM confirmed that the facility did not reassess a detainee following an incident of abuse or victimization, nor did the classification staff interview the detainee during the reassessments.

Does Not Meet: The Audit team reviewed 10 detainee A-files and 12 detainee detention files and confirmed that not all detainees are being re-assessed in accordance with subpart (e) of the standard. Reviewed files confirmed that reassessments are untimely, and not completed following and incident of abuse or victimization. The Lead Auditor's interview with the APM further confirmed that reassessments are not being done in accordance with subpart (e). The facility must complete risk reassessments between 60 and 90 days from the date of the initial risk 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 Auditor will request a list of detainees housed beyond 90 days to select random detainee files for compliance review on the PREA risk assessment process and five detainee files for reassessment based upon receipt of additional, relevant information or following an incident of abuse or victimization, if applicable.

Recommendation: The classification staff should meet face to face with the detainee when completing their reassessment to get an accurate account of the detainee's time at KNSPC.

(f): Facility policy KRO/20.2.11 states that "detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked during the intake process." Interviews with the PSA Compliance Manager, intake staff, and Classification Supervisor indicated detainees are not disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to the standard.

(g): The interview with the PSA Compliance Manager indicated appropriate controls are placed on all detainee information including risk assessments and sexual abuse allegations; however, a review of 12 detention files confirmed that the Investigative Findings and Responsive Actions Notification forms are also filed in the detention file, as opposed to just the detainee's A-file, as directed on the notification form. This file is accessible to all employees, and therefore, available to more than those with a need to know.

Does Not Meet: A review of 12 detainee detention files confirmed that the Investigative Findings and Responsive Actions Notifications are inappropriately filed in the detention file making the form accessible to all employees, including facility staff. Per direction provided on the form, this information is to be filed in the investigative file and the detainee's A-file. The facility must remove all Investigative Findings and Responsive Actions Notifications from the detention files to eliminate accessibility to all staff, for compliance. The facility must also implement appropriate controls or policy directives to ensure that sensitive information is not accessible to all staff or exploited to the detainee's detriment by staff. The facility must provide a process to control accessibility of sensitive information to all staff and document the implementation of this process. A random review of the detention files will be completed to ensure sensitive information is not maintained in the detention files accessible to all staff.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Policy KRO/20.2.2 outlines how the facility uses the information obtained through the RCA tool conducted at initial screening when considering detainee housing, recreation, voluntary work programs and other activities. In review of 10 detainee A-files, the Lead Auditor determined the facility is utilizing the data collected from the RCA tool, such as the detainee's age, whether the detainee has mental, physical or development disability, previous disciplinary history, alleged offense and criminal history, whether the detainee is perceived to be LGBTI or is gender non-conforming to determine initial housing. However, the Lead Auditor could not confirm the facility utilized the detainee's physical build or prior convictions of sexual abuse in their determinations, which is captured in the IHSC Intake Screening. It does not appear that the information captured in the IHSC Intake Screening is utilized in making an initial housing determination. In addition, the detainee's files did not confirm the facility uses the information gathered pursuant to 115.41's requirements to make individual determinations regarding recreation, work, and other activity decisions. While on-site, the Audit team reviewed an additional 12 detainee files. Included in the detainee file, but not the 10 A-files reviewed, was an "In-Processing Special Vulnerability Questionnaire" that, according to the Intake supervisor, was developed by the facility and is used to gather detainee information upon intake. The form includes whether the detainee has a mental, physical, or developmental disability, the age of the detainee, whether the detainee has self-identified as LGBTI 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 form does not take into consideration the physical build and appearance of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, or whether the detainee has any convictions for sex offenses against an adult or child. The form includes a section regarding housing that includes General Population, General Population with referral to medical care, isolation after requesting protective custody, and isolation until medically evaluated, however, this section was not utilized in any of the 12 detainee files reviewed by the Audit team. In addition, the Audit team noted that a number of the vulnerability questionnaires were completed by the detainee and not the intake staff as required. During the on-site portion of the Audit, the Intake Supervisor indicated that the facility housed detainees strictly by security level, confirming that the vulnerability portion of the file is not taken into consideration when determining housing. This was observed during the housing determination of a detainee during intake. While on-site, during an interview with mental health staff, the Audit team was advised that if mental health received information that the detainee had a sexual abuse history, they would not share the information with facility staff responsible for housing, recreation, and other activities. The Lead Auditor reviewed on-site a copy of a "Voluntary Work Program, Volunteer Worker Screening Form," which did not include the intake screening information for making decisions for recreation and other activities. Interviews with the classification and intake staff, and the APM, further confirmed the facility did not utilize the assessment information, as required in the standard, to determine recreation, work, and other activity decisions.

Does Not Meet: The facility's "In-Processing Special Vulnerability Questionnaire" was not utilized in any of the 12 detainee files reviewed by the Audit team. The facility does utilize the data collected from the RCA tool, such as the detainee's age, whether the detainee has mental, physical or development disability, previous disciplinary history, alleged offense, and criminal history, whether the detainee is perceived to be LGBTI or is gender non-conforming, nor the information captured in the IHSC Intake Screening in making an initial housing determination. In addition, the Intake Supervisor indicated that the facility housed detainees strictly by security level, confirming that the vulnerability portion of the file is not taken into consideration when determining housing. Mental health staff interviewed confirmed that, if mental health received information that the detainee had a sexual abuse history, they would not share the information with facility staff responsible for housing, recreation, and other activities. The Lead Auditor reviewed on-site a copy of a "Voluntary Work Program, Volunteer Worker Screening Form," which did not include the intake screening information for making decisions for recreation and other activities. Interviews with the Classification and Intake staff, and the APM, further confirmed the facility did not utilize the information as required in the standard to determine recreation, work, and other activity decisions. The facility must use the information from the risk assessment under 115.41 to make informed determinations for housing, recreation, voluntary work, and other activities, to ensure the safety of each detainee. The Auditor will request intake lists from various days to select random detainee to review the detainee files for the intake risk assessment and the individualized determinations for housing, recreation, voluntary work, and other activities for standard compliance.
(b): Policy KRO/20.3.3 states "in making assessments and housing decisions for transgender or intersex detainees, the facility will consider the detainee's gender and self-identification, and assessment of the effects of placement on the detainee's health and safety." The policy further indicates "transgender and intersex detainees shall be reassessed at least twice a year." During the Remote Interview phase of the audit, two specialized interviews with transgender detainees were conducted by the Second Auditor. Neither detainee recalled being reassessed and only one reported being seen by medical. The Lead Auditor reviewed the files of the two transgender detainees and was unable to confirm that the detainees were referred to medical or mental health upon intake. One detainee's file was accompanied by the detainee's medical and mental health files. The detainee file labeled the detainee as transgender on January 7, 2020, however, the detainee arrived at KNSPC on December 1, 2019. In the medical and mental health files provided, neither indicated that the detainee was transgender upon intake. There were no additional records provided that could confirm the detainee was referred to medical or mental health upon the detainee disclosing transgender status on January 7, 2020. The documentation provided also could not confirm that transgender and intersex detainees were reassessed at least twice a year. Interviews with intake and medical staff indicated that a medical and mental health professional will be consulted on a case-by-case basis, to determine whether the placement would present management or security concerns. There were no transgender or intersex detainees to interview during the on-site portion of the Audit. A review of an additional transgender detainee's detention file, provided on-site, confirmed the detainee did not receive a reassessment as mandated by the standard.

Does Not Meet: Following the review of two transgender detainee A-files, and one transgender detainee's detention file, in conjunction with interviews with intake and medical staff who indicated that a medical and mental health professional will be consulted on a case-by-case basis as

opposed to consulting with medical or mental health staff on all transgender housing assessments, the Lead Auditor confirmed that not all transgender, or intersex, detainees are assessed upon intake to determine if the facility's placement of a transgender or intersex detainee is consistent with the safety and security of the facility as required by the subpart (b) of the standard. The Lead Auditor further confirmed following the review of a transgender detainee's detention file that the facility does not re-assess each transgender or intersex detainee at least twice a year to review and threats to safety experienced by the detainee. The facility must consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety, consistent with the safety and security considerations of the facility, which includes a consult by medical or mental health staff as soon as practicable on the assessment. The facility must reassess each transgender or intersex detainee at least twice each year to review any threats to safety experienced by the detainee. The facility must provide two intake risk screening of a transgender or intersex detainee with facility housing placement determination that considers the detainee's self-identification and the health and safety of the detainee.

Recommendation: The classification staff should meet face to face with the detainee when completing their reassessment to get an accurate account of the detainee's time at KNSPC.

(c): Policy KRO/20.4.5 (Personal Hygiene) states that "when operationally feasible, transgender and intersex individuals shall be given an opportunity to shower separately from other detainees." Interviews with intake staff, the Classification Supervisor, and security staff produced various answers as to whether a transgender or intersex detainee had the opportunity to shower separately from other detainees. Some interviewed security staff stated they would be taken to the SMU, while others stated they would be allowed to shower in the unit before regular showers, and some did not know. The Auditor was unable to determine, through interviews with the two transgender detainees, whether the detainees were able to shower separately as one was housed in SMU and afforded the opportunity to shower alone, and the other detainee did not request to shower separately and therefore was unaware of the procedure.

Recommendation: The facility should train facility staff on the policies and procedures regarding separate shower availability for transgender and intersex detainees.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c)(d)(e): Policy KRO/20.2.12 Special Management Units (SMU) states "the facility's use of administrative segregation to protect detainees vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, and as a last resort. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. In addition, the facility will consult with the ICE FOD to determine if a less restrictive housing or custodial option is appropriate and available or whether transfer may be appropriate to a hospital or another facility where the detainee can be housed in general population or in an environment better suited to the needs of the detainee." Per policy KRO/20.2.11 "detainees should 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." Policy KRO/20.2.11 dictates "if segregated housing is warranted, the facility will take the following actions: a supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted; a supervisory staff member will conduct an identical review after the detainee has spent seven days in administrative segregation, and weekly after for the first 60 days and every 10 days thereafter, at a minimum." The Lead Auditor reviewed the file of a detainee, submitted with the PAQ documents, placed in administrative segregation for protection purposes, and confirmed that the proper reviews were conducted by the facility. An interview with the facility staff line supervisor who oversees the SMU confirmed that detainees who have been placed in administrative segregation for protective custody have access to programs, services, visitation, counsel, and other services available to the general population to the maximum extent possible. A review of SMU housing records, submitted with the PAQ documents, confirmed that an administrative segregation for protection purposes, the detainees were afforded showers, medical attention, recreation, and visitation. The Lead Auditor confirmed through an interview with the SMU supervisor, that if access to these opportunities is restricted, the facility would document the reasons why. In addition, the facility will notify the appropriate ICE FOD no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in segregation based on a vulnerability to sexual abuse or assault. An interview with the Supervisor who oversees SMU confirmed that proper reviews are conducted on all detainees placed in segregated housing for the purpose of protecting the detainee from sexual abuse. Prior to the on-site portion of the audit, the Second Auditor interviewed a transgender detainee housed in protective custody; however, based on the difficulty of the interview it could not be determined if the detainee was housed in SMU due to protection of sexual abuse or due to being quarantined for COVID screening. There were no detainees housed in Protective Custody who were vulnerable to sexual abuse or assault during the on-site portion of the audit. A review of Policy 14-2 by the Lead Auditor confirmed written procedures were developed in consultation with the ICE FOD who has jurisdiction for the facility.

§115.51 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy KRO/20.2.11 outlines the facility's approach to ensure detainees have multiple ways to privately report sexual abuse and retaliation for reporting sexual abuse, and staff neglect or violation of responsibilities that may have contributed to any incidents. Submitted with the facility's PAQ were directives on how detainees can contact their consular official, the DHS OIG or, as appropriate, another designated office, to confidentially and, if desired, anonymously report incidents of sexual misconduct. Interviews with random detainees indicated to the Second Auditor that they are aware of the processes in place to report incidents of sexual misconduct, e.g., report to a staff member, file a grievance, place a phone call, contact their consular official, the DHS OIG or, as appropriate, another designated office to anonymously report. During intake/orientation, detainee's sign that they received a copy of a handbook, but the documentation provided is not clear as to whether they received the ICE National Detainee Handbook, the facility's Detainee Handbook Local Supplement, or both. During the on-site portion of the audit, the Audit team observed the intake processing of a detainee who did not receive the ICE National Detainee Handbook. Additionally, while conducting the tour, the Audit team attempted to make an anonymous call following the steps printed on the facility phones and written instructions on the bulletin boards. These calls could not be completed. During the on-site audit portion, an interview with the APM confirmed that the anonymous call can be completed, however, the completion time was over 10 minutes for the detainee to complete the call. The facility did make attempts to rectify the issue with the reporting completion times, however, the issues still existed upon the completion of the on-site audit.

Recommendation: The facility should replace the information on the phones on how to anonymously report an allegation, the information l currently on the detainee telephones is incorrect directions for the detainee to report an allegation anonymously. In addition, the facility should place the updated information in the facility's Detainee Handbook Local Supplement. Finally, the facility should work closely with the telephone company to rectify the amount of time needed to complete an anonymous report of sexual abuse.

(c): Policy KRO/20.2.11 outlines procedures for staff to "accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports." Interviews with the PSA Compliance Manager, security staff, including line staff and first-line supervisors, stated if they received a report of sexual misconduct, they would document the allegation on a facility incident report and forward it on through the appropriate channels for investigation. In review of 16 completed sexual abuse investigations, nine allegations were reported to facility staff by the alleged victim, one was reported by a third party, and six were grievances submitted by the alleged victim. The Lead Auditor determined all but two cases were completed in accordance with the standard. In the one case, staff failed to report an incident of sexual abuse reported by the alleged victim. As a result, the facility determined the staff did not follow policy and was subsequently terminated from employment. In the other case, the staff person failed to report the incident of sexual abuse and submitted the required incident report four days following the detainee reporting the sexual abuse incident and after the allegation was reported to the facility through the detainee's attorney.

Does Not Meet: In review of 11 allegations of sexual abuse, where the detainee reported to staff, the Lead Auditor confirmed that in two of the cases, the facility staff failed to promptly report, and document, an incident of sexual abuse as required by subpart (c) of the standard. The facility must conduct refresher training with staff on the reporting and proper document of any verbal reports of sexual abuse. The facility must provide a copy of the training materials and documentation that staff completed the training for compliance review.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): Policy KRO/20.6.2 Grievance System details the formal grievance process for detainees to utilize involving allegations of an immediate threat to their health, safety, or welfare, and related to sexual abuse. "Grievances may be brought to a designated grievance officer (GO) or directly to the OIC or their designee. Detainees are permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. A detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives with filing a grievance relating to sexual misconduct. Facility staff are required to bring all medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility does not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse." Policy further states that "the detainee shall be provided with a written or oral response within five days of receipt of the grievance and the ICE FOD shall review the grievance appeal and issue a decision within five days of receipt of the appeal. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE FOD at the end of the grievance process." Interviews with the Grievance Coordinator and facility line staff, during the contingency portion of the Audit, could not corroborate the above-mentioned policy. The Grievance Coordinator was new to the position and could not accurately answer the interview questions. The majority of facility line staff advised they do not handle grievances and that detainees place grievances in the "Grievance Box." When pressed, some facility line staff indicated they would accept a grievance if handed to them while others indicated they would not handle a grievance under any circumstance. During the on-site portion of the Audit, the Audit team, through interviews with facility staff and the facility's PSA Compliance Manager, confirmed that the procedure in place was being affected by the current pandemic. The Grievance Coordinator was working remotely and not completing daily rounds to gather potential emergency grievances in the housing units. In addition, the "grievance box" located in the cafeteria was no longer accessible to the detainees, as the areas was closed due to the pandemic. According to a facility memo submitted with the PAQ and an interview with the Grievance Coordinator, the facility has not received any grievances in the past 12 months regarding allegations of sexual abuse. Therefore, no grievances were submitted to the Lead Auditor to review. However, five sexual abuse allegations submitted by the facility recorded that the allegations were reported through the grievance system. During the on-site portion of the Audit, the Lead Auditor was able to review a sexual abuse grievance submitted by a detainee he submitted to the grievance officer utilizing the "electronic pad" issued to each detainee. According to the grievance submitted, the detainee reported an incident of sexual abuse on 12/22/2020. The Grievance Coordinator responded to the detainee the same day, advising the detainee that the grievance was forwarded to ICE and AGS Supervisors and PREA Coordinators for investigation. The Grievance Coordinator then labeled the grievance as "open." The grievance remained opened until 01/05/2021 when it was determined unfounded and officially closed. Therefore, the facility did not issue a decision on the grievance within five days of receipt. On 1/7/2021, the detainee filed an appeal and was issued a decision on 01/26/2021, confirming compliance with this part of the standard. Interviews with detainees did confirm they are aware of the facility grievance process and that they can request assistance in filing a grievance if needed.

Does Not Meet: The facility's procedure for filing an anonymous grievance is not being followed. The facility cafeteria, where the grievance box is located, was closed to detainee access and the Grievance Officer is working remotely. During the interviews with facility line staff, some staff indicated that they would not accept a detainee grievance under any circumstances. Additional interviews with facility staff and the facility PREA Compliance Manager, further confirmed that at the time of the on-site audit, the facility had not adjusted the procedures to allow detainees a way to submit a grievance of an incident of sexual abuse since the Grievance Officer was working remotely and was not collecting grievances daily from the housing units. In review of the one available detainee grievance, it was 15 days from the opening of the grievance until the detainee was notified that the grievance was closed as unfounded. The facility agreed that the procedures needed to be updated to provide a process to collect grievances forms the housing units daily during the pandemic, however, they did not provide the Audit team with a solution prior to the conclusion of the on-site portion of the audit. The facility must develop a process for detainees to submit sexual abuse grievances, including time sensitive sexual abuse grievances that involve an immediate threat to detainee health, safety, or welfare, to the Grievance Coordinator or other designee during disruptions in normal operating procedures and the facility must issue a decision on all sexual abuse grievances within the standard timeframes. The facility must also submit written guidelines to ensure sexual abuse grievances, including time sensitive grievances are retrieved and submitted for review in a timely manner. The facility must provide the written protocols for retrieving grievances to ensure timely processing and a list of all sexual abuse grievances reported within a determined time frame; the Auditor will select random grievance files to review to determine standard compliance.

§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): Policy KRO/20.2.11 outlines the facility's procedures to provide outside confidential support services that will provide services to support in the areas of crisis intervention, counseling, investigation, the prosecution of sexual abuse perpetrators, and to address victim's needs. KNSPC did not supply the Lead Auditor with a copy of an MOU with a rape crisis center, however they did provide the Lead Auditor with a copy of a posting for Roxcy

Bolton Rape Treatment Center. Further emails provided to the Second Auditor, during the on-site portion of the Audit, confirmed the facility continues its efforts to obtain a signed MOU from the treatment center. The Second Auditor did attempt to reach out to the treatment center during the on-site portion of the Audit, however, the treatment center did not return her call. Of the 16 completed sexual abuse investigation packets reviewed, the facility offered the detainee/victim with a Detainee Assistance Alternatives flyer; however, the services of the Rape Crisis Center were not utilized during the audit period. Detainees interviewed were generally unaware of the services of the rape crisis center. Two detainees interviewed by the Second Auditor indicated they were not offered services following their allegation of sexual abuse and requested the services during the interview. The facility was immediately advised by email of their request for services by the Lead Auditor. The facility responded that they would provide the Detainee Assistance Alternatives flyer to the two detainees. A confirmation that the flyers were provided was sent to the Lead Auditor by email notification after the Lead Auditor requested follow-up.

(c): During the on-site portion of the Audit, the Audit team was able to confirm that the detainees are advised of the services Roxcy Bolton provides, including a mailing address and a toll-free telephone number through signage posted in all the housing units. A copy of the facility's Detainee Handbook Local Supplement, submitted to the Lead Auditor with the PAQ, included the local organization that can assist detainees who have been victims of sexual abuse, including mailing addresses and hotline telephone numbers; however, upon review of the facility's Detainee Handbook Local Supplement, during the on-site portion of the Audit, the Lead Auditor discovered that the information was removed from the handbook with the incorporation of the DHS-prescribed Sexual Assault Awareness Information pamphlet into the facility's Detainee Handbook Local Supplement. **Recommendation:** The facility should place back into the facility's Detainee Handbook Local Supplement the information regarding the local organization that can assist detainees who have been victims of sexual abuse, including mailing addresses and hotline telephone numbers.

(d): Information outlined in the facility's Detainee Handbook Local Supplement indicates, prior to giving detainees 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 requirements. Detainees are advised through the facility's Detainee Handbook Local Supplement, telephone calls may be recorded and monitored in accordance with the facility's policy governing the monitoring of their communications. Interviews with random detainees also indicated that they are aware that phone calls are or can be monitored and allegations of sexual abuse will be forwarded and investigated in accordance with mandatory reporting laws.

§115.54 - Third-party reporting.

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

Notes:

Policy KRO/20.2.11 states that "the facility shall establish a method to receive third-party reports of sexual abuse in its facility and that each facility shall make available to the public information on how to report sexual abuse on behalf of a detainee." The policy, however, does not establish a method for staff to receive the reports. KNSPC website (www.ice.gov/detention-facility/krome-service-processing-center) and the ICE website (www.ice.gov/prea) provides the public with information (telephone number & address) regarding third-party reporting of sexual abuse on behalf of the detainee. The Auditor viewed both websites, reviewed the documentation on the ICE ERO Detention Reporting and Information Line (DRIL), and a copy of the poster submitted by the facility with the PAQ and confirmed the information regarding third-party reporting of sexual abuse on behalf of the detainee. Interviews with the OIC and the PSA Compliance Manager confirm they are aware of the requirement to accept sexual abuse notifications from third parties. Interviews with the OIC, PSA Compliance Manager, and random facility staff confirmed they would accept a sexual abuse allegation made by a third party. Interviews with detainees confirmed they were aware of third-party reporting and that they were knowledgeable on how to do so. A review of 16 KNSPC sexual abuse investigations confirmed the facility received one sexual abuse allegation from a third party during the audit period. The review confirmed that the allegation was accepted, and an investigation was completed as mandated by the standard.

§115.61 - Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(c): Policy KRO/20.2.11 outlines the responsibilities of staff who are required to report, immediately, any knowledge, suspicion, or information regarding incidents of sexual abuse, retaliation against detainees or staff who have reported incidents of sexual abuse, or staff neglect or violations of responsibilities that may have contributed to an incident or retaliation. According to the PAQ, and a review of the documentation provided, the agency did review and approve the facility's policy and procedures. Staff members who become aware of alleged sexual abuse will immediately follow the reporting requirements set forth in the policy's section L (Reporting, Notifications, and Confidentiality). Policy KRO/20.2.11 further states "that staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions". Interviews with random facility staff confirmed that staff are knowledgeable of their duty to not reveal any information related to a sexual abuse report to anyone other than to extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions.

(b): Policy KRO/20.2.11 "requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Employees are required to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible. Staff are required to promptly document any verbal reports as well." Interviews during the contingency portion of the audit with the PSA Compliance Manager, AFOD, and random facility staff, it was clearly articulated by staff the protocols in place as it relates to staff reporting duties, with the exception of how staff can report allegations of sexual misconduct outside of their normal supervisory chain of command, if needed. The policy states that "KNSPC shall have written policy and procedures for a SAAPI program that includes procedures for immediately reporting sexual abuse allegations, including a method by which staff can report outside the chain of command;" however, these procedures are not outlined further in KRO/20.2.11. The Second Auditor was able to confirm compliance through random interviews with facility staff, who were knowledgeable as to how to report an incident of sexual abuse outside the chain of command. A review of the 10 sexual abuse investigations, where the detainee reported the allegation to staff, confirmed that not all staff immediately reported the allegation as required by the standard. In one of the allegations, the facility staff member failed to report an allegation and in response, the facility terminated the employee for failing to adhere to PREA policies, by not reporting the allegation, and then falsifying records in an effort to cover up his failure to follow KNSPC's reporting policy. The facility provided a copy of the termination letter to document the termination. During the review of the second sexual abuse investigation, a facility staff member failed to immediately report the incident and then reported the

incident four days later. An investigation was started two days after the incident as a result of an email from the detainee's attorney's reporting the incident. According to the results of the investigation, there was no follow-up discipline for the facility staff member involved.

Does Not Meet: In review of 10 allegations of sexual abuse, where the detainee, or a third party, reported a sexual abuse allegation to staff, the Lead Auditor confirmed that in two of the cases, the facility staff failed to promptly report, and document, the allegation as required by subpart (b) of the standard. All facility staff are required to report immediately and according to agency and facility policy any knowledge, suspicion, or information regarding an incident of sexual abuse. The facility must provide and document refresher training to all facility staff on reporting requirements. The facility must provide a copy of the training materials and documentation of training completed by staff for compliance review.

(d): KNSPC does not house juvenile detainees. The Lead Auditor received no evidence that the facility houses or has housed potentially vulnerable detainees within the past year. Interviews with the PSA Compliance Manager indicated if they were to receive a report of sexual abuse from a detainee identified as a vulnerable adult, the incident would be reported to the designated state or local services agency under applicable mandatory reporting laws.

§115.62 - Protection duties.

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

Policy KRO/20.2.11 outlines the facility's approach when staff learns that a detainee is subject to a substantial risk of imminent sexual abuse. Immediate action is taken to protect the detainee. Interviews with the OIC, PSA Compliance Manager, and random facility staff revealed if a detainee is determined to be at an imminent risk of sexual abuse, the detainee would be immediately removed from the hazard. In review of 16 sexual abuse investigations completed during the audit period, the Lead Auditor determined the facility took the appropriate action required to protect detainee victims, with the exception of two cases, where the facility staff person who received the report, failed to report the allegation and to immediately take steps to separate the victim from the alleged perpetrator. Given the Lead Auditors interviews with multiple staff, who clearly understand their duty to protect the detainee from imminent danger, and a review of 16 detainee incident investigations where the majority of staff were in compliance with the standard, the Lead Auditor confirmed the facility is in substantial compliance with standard 115.62.

§115.63 - Report to other confinement facilities.

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

(a)(b)(c)(d): Policy KRO/20.2.11 outlines the facility's process for reporting to other confinement facilities. The policy states "upon receiving an allegation that a detainee was sexually abused while housed at another facility, the facility whose staff received the allegation shall notify the FOD and the appropriate administrator of the facility where the alleged abuse occurred. The notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. The facility will document it has provided such notification. The facility where the alleged abuse occurred shall then ensure the allegation is referred for investigation and reported to the appropriated FOD." It should be noted the facility reported that there were no recorded claims of sexual allegations occurring at another facility, or another facility reporting an allegation that occurred at KNSP, during the audit period. This was confirmed in an interview with the OIC and the Lead Auditor's review or 16 sexual abuse allegations. The interview with the OIC also corroborated that the facility would follow policy KRO/20.2.11 when reporting allegations of sexual abuse to other confinement facilities if required. She further indicated they are aware of the proper steps for making such notifications, and for maintaining documentation if a notification is made. The OIC indicated documentation of such notifications would be maintained through electronic means, i.e. email correspondence, faxes, facility incident reports.

§115.64 - Responder duties.

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

(a)(b): Policy LOP 8.6.2C Prison Rape Elimination Act (PREA) states "if a sexual assault occurs at KNSPC, the Akima Global Services (AGS) security team will separate the alleged victim and bring them to the clinic for evaluation by medical staff." Policy KRO/20.2.11 dictates that "when there is an allegation that a detainee was sexually abused, the first security staff member to respond to the report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect evidence." Interviews with security staff, policy review, and investigative files review indicates all four elements of the standard is accounted for during the responder duties. According to the facility PAQ and staff interviews there has not been a non-security staff member who acted in the capacity of a first responder. In review of 16 completed sexual abuse investigations completed during the audit period. the Lead Auditor confirmed that there has not been a non-security staff member who acted in the capacity of a first responder. Policy KRO/2.11 and interviews with security staff, and security supervisors, corroborate that non-security first responders are required to request the alleged victim to not take any actions that could destroy physical evidence and are required to notify security staff. In review of 16 completed sexual abuse investigations completed during the audit period, the Lead Auditor determined facility staff appropriately responded to the report, with the exception of two cases, where the facility staff person who received the report, failed to report the allegation and follow first responder duties. Given the Lead Auditors interviews with multiple staff, who clearly understand their duties as a first responder, and a review of 16 detainee sexual abuse investigations where the majority of staff were in compliance with the standard, the Lead Auditor confirmed the facility is in substantial compliance with standard 115.64.

§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)(c)(d): Policy KRO/20.2.11 states "the KNSPC should use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART) which in accordance with community practices, includes a medical practitioner, a mental health practitioner, a security staff member and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise." Interviews conducted with the OIC and PSA Compliance Manager indicated the facility uses a coordinated, multidisciplinary team approach when responding to incidents of sexual abuse. Facility LOP 8.6.2C Prison Rape Elimination Act PREA delineates the responsibilities for a coordinated response to staff-on-detainee allegations of sexual abuse and detainee-on-detainee sexual abuse allegations. ICE Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAPPI) dictates "if a victim is transferred between detention facilities or holding facilities, or to any non-ICE facility, ensure that, as permitted by law, the receiving facility is informed of the incident and the victim's potential need for medical or mental

health care or victim services (unless, in the case of transfer to a non-ICE facility, the victim requests otherwise." During the audit period, KNSPC did not have any substantiated incidents of sexual abuse that involved the detainee/victim being transferred to another facility. Interviews with the OIC and PSA Compliance Manager confirmed they are aware of the facility's coordinated response procedures for allegations of sexual abuse. Both the OIC and the PSA Compliance Manager advised the Auditor proper notifications per the standard would be made to the receiving facility, to include a DHS immigration detention facility covered by subpart A or B, if a detainee was to be transferred.

§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:

Policy KRO/20.2.11 states that "staff, contractors and volunteers suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation. 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 agency 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. Contractors or volunteers who have engaged in sexual abuse or assault are prohibited from contact with detainees. The facility will take appropriate remedial measures and considers whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards." The interview with the OIC corroborated that staff, contractors, or volunteers who are being investigated for sexual abuse allegations or any other serious misconduct involving a detainee are prohibited from having contact with detainees. Seven sexual abuse investigation files were reviewed by the Lead Auditor which involved five facility staff. In all instances, the facility staff was reassigned to duties that did not involve contact with detainees. KNSPC reported no incidents of sexual abuse involving contractors or volunteers during the audit period.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy KRO/20.2.11 outlines the facility's procedures for protection against retaliation. The policy states "staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least 90 days following a report of sexual abuse, the facility will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation." The policy states that "KNSPC will continue such monitoring beyond 90 days if the initial monitoring indicates a need to do so." During the interview with the Lead Auditor, the OIC indicated she was unaware of how the monitoring of staff and/or detainees was conducted at KNSPC. Documents provided with the PAQ documented that monitoring of detainees was conducted for the first 30 days, but monitoring thereafter could not be confirmed, nor could the documents confirm if the facility monitored detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff as required by the standard. However, during an interview with the facility's PSA Compliance Manager, while on-site, the Lead Auditor determined that the detainee is monitored for at least 90 days following a report of sexual abuse and will continue to monitor beyond 90 days, if the initial monitoring indicates a continued need. The facility's PSA Compliance Manager further confirmed that the monitoring takes into consideration detainee disciplinary reports, housing or program changes, and negative performance reviews. He does not contact the detainee, at any time during the monitoring period for a face-to-face meeting, to discuss whether the detainee needs emotional support services for fear of retaliation for reporting sexual abuse or for cooperating with investigations. In addition, the PSA Compliance Manager further confirmed during the interview, that the facility does not have a procedure to monitor retaliation against staff, nor are there support services available for staff who fear retaliation for reporting sexual abuse or for cooperating with investigations.

Does Not Meet: During the on-site portion of the Audit, the Lead Auditor confirmed through documentation for retaliation monitoring, that there is a process in place to monitor detainees for retaliation, as required by the standard; however, there is no face-to-face interaction to determine a need for emotional services due to a fear of retaliation for reporting sexual abuse or for cooperating with investigations or documentation that demonstrated the facility monitors detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff as required by the standard. Also, detainee retaliation monitoring could not be confirmed for the 90-day period. In addition, the PSA Compliance Manager further confirmed the facility does not have a procedure to monitor retaliation against staff and there are no support services available for staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. The facility must develop a process to monitor staff for retaliation and act promptly to remedy any such retaliation as required by policy and standard. The facility must provide examples of retaliation monitoring for detainees and staff for at least 90 days following a report of sexual abuse and any actions that may have been taken to remedy any such retaliation. The documentation needs to demonstrate face-to face monitoring and detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff are monitored for possible retaliation for standard compliance. standard

§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): Policy KRO/20.2.11 dictates that "care shall be taken to place the detainee in a supportive environment that represents the least restrictive housing option possible and that victims shall not be held longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee." Policy KRO/20.2.11 further states that "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 reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." According to a facility memo submitted with the PAQ, the facility had not used segregated housing to protect a detainee/victim of sexual abuse. In review of 16 completed sexual abuse investigations, the Auditor saw no indication that a detainee was placed in segregation for protective measures. An interview with the facility staff line supervisor in charge of the SMU confirmed that a detainee/victim would be placed in the least restrictive housing option possible and that the detainee/victim would not be held for more than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. The facility staff line supervisor further confirmed that the detainee/victim would not be returned to the general population until a proper reassessment was completed that took into consideration any increased vulnerability of the detainee as a result of the sexual abuse.

(d) Interviews with the OIC and PSA Compliance Manager indicated the facility will notify the appropriate ICE FOD whenever a detainee victim has been placed in administrative segregation and normally as soon as possible but would not exceed 72 hours in accordance 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): Policy KRO/20.2.11 states that "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." Policy KRO/20.2.11 further dictates that "Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity." In addition, the policy further states that "all investigations into alleged sexual assault must be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators. In the event the investigation is being conducted by a non-federal investigating agency, the facility shall request that the investigating agency follow the applicable requirements of the standard." In a facility memo submitted with the PAQ, the facility attempted to enter into a MOU with the Miami-Dade Police Department, the entity assigned to conduct criminal investigations into allegations of sexual abuse. However, the Miami-Dade Police Department refused, as they are required to respond if needed based on KNSPC being a federally owned facility in their local jurisdiction. The policy further states that "written procedures shall include provisions for (a) preservation of direct and circumstantial evidence including any available physical and DNA evidence and any available electronic monitoring data; (b) interviewing alleged victims, suspected perpetrators, and witnesses; (c) reviewing prior complaints and reports of sexual abuse or assault, involving the suspected perpetrator; (d) assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individuals status as detainee, staff or employee and without requiring any detainee who alleges sexual abuse to submit to a polygraph; (e) an effort to determine whether actions or failures to act at the facility contributed to the abuse; (f) documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and (g) retention of such reports for as long as the alleged abuse is detained or employed by the agency of facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, (subpart b) to ensure the criminal investigation in not compromised by an internal administrative investigation." In review of policy, procedures, and 16 completed sexual abuse investigations, the Lead Auditor determined all elements of the standard were completed as required. Interviews conducted with the AFOD, PSA Compliance Manager, and investigators corroborated the above stated policy.

(e) Facility policy KRO/20.2.11 dictates that "the departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." After a review of 16 completed sexual abuse investigations, the Lead Auditor determined that all the investigations were closed prior to the detainees being released or transferred. Interviews with the AFOD, PSA Compliance Manager, and facility investigators corroborated the above stated policy. Interviews with the OIC, PSA Compliance Manager, and investigators revealed an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency.

(f) Per KRO/20.2.11 "when outside law enforcement agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." The review of 16 sexual abuse allegations submitted by the facility confirmed that no sexual abuse allegations were criminal in nature; and therefore, no cases were referred to the Miami-Dade Police Department for investigation. In an interview with the facility investigator, it was confirmed that the facility shall cooperate with outside investigators and shall continue to stay informed about the progress of the investigation, by reaching out to the Miami-Dade Police Department, on a continuous basis, until the conclusion of the investigation.

§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:

Policy KRO/20.2.11 states that "the KNSPC shall not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated." Upon review of 16 sexual abuse investigation files, the Lead Auditor determined investigations are completed in accordance with the standard. Interviews with the facility investigators and PSA Compliance Manager verified the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated.

§115.73 - Reporting to detainees.

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

Notes:

Policy KRO/20.2.11 states that "the agency shall, when the detainee is still in immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation of sexual abuse, notify the detainee as to the result of the investigation and any responsive action taken." The policy does not however, indicate, that if the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee. A review of 16 sexual abuse investigation files confirmed that all detainee notifications, or attempted notifications, are documented on a form entitled "Investigative Findings and Responsive Actions Notifications." The Investigative Findings and Responsive Actions Notifications are signed by the detainee verifying that such notification has been received, and are filed in the detainee's investigation, detention, and A-files. The Lead Auditor reviewed 16 sexual abuse investigation files and all files confirmed that detainees were notified by the facility of the facility's investigative outcome per policy and the standard requirements. Interviews with the OIC, investigators, and PSA Compliance Manager confirmed the process in place for reporting investigative outcomes to the detainee.

Recommendation: The facility should update policy KRO/20.2.11 to include the requirement of the standard that states, "if the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee."

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d) Policy KRO/20.2.11 states "staff are subject to discipline to include termination for violation of the department's sexual abuse and sexual harassment policies." The PAQ, in addition with interviews with the OIC and PSA Compliance Manager confirmed the facility's policies and procedures regarding disciplinary or adverse actions for staff were provided to the agency for review and approval. Removal from their position and from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in those acts of sexual abuse, as

defined under paragraphs (a)–(d) and (g)–(h) of "Staff on Detainee Sexual Abuse and/or Assault" and in "B. Acts of Sexual Abuse and/or Assault" as noted in KRO/20.2.11. In addition, per KRO/20.2.11 "KNSPC shall report all incidents of substantiated sexual abuse by staff, and all removals of staff, or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies unless the activity was clearly not criminal and shall also report all such incidents of substantiated abuse, removals or resignations in lieu of removal to the ICE FOD, regardless of whether the activity was criminal and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known."

During the audit period, the facility has not had an allegation involving staff sexual misconduct. Therefore, files demonstrating termination, resignation, or other disciplinary actions were not available for review. An interview with the AFOD confirmed staff are subject to discipline for violations of the department's sexual abuse policies and termination is the presumptive disciplinary sanction for a staff member who has engaged in sexual abuse. The interview with the AFOD further indicated removals or resignations for violations of agency or facility sexual abuse policies would be appropriately handled and reports of removals or resignations for violations of agency or facility sexual abuse policies would be forwarded to any relevant licensing bodies by the facility to the extent known.

§115.77 - Corrective action for contractors and volunteers.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy KRO/20.2.11 states "any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees. The policy further states that incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies, unless the activity was clearly not criminal and that the facility shall also report such incidents to the ICE FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." In addition, the policy states "the facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards." An interview with the OIC confirmed volunteers and contractors are subject to termination and/or prohibited contact from detainees for violations of the department's sexual abuse policies. Further, the facility will take appropriate measures when considering whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within the standard. A review of the facility's sexual abuse allegation investigations indicated that there were no incidents of sexual abuse that involved volunteers or contractors.

A review of 16 sexual abuse investigation files confirmed that, during the audit period, the facility has had two documented incidents in which contract staff have failed to follow facility sexual abuse policies, by failing to immediately report an allegation of sexual abuse. In one of the allegations, the contract staff member failed to report an allegation and in response, the facility terminated the individual for failing to adhere to PREA policies, by not reporting the allegation and then falsifying records, in an effort to cover up his failure to follow KNSPC's reporting policy. The facility provided a copy of the termination letter to document the termination. During the review of the second sexual abuse investigation, a contract facility staff member failed to immediately report the incident and then reported the incident four days later. An investigation was started two days after the incident as a result of an email from the detainee's attorney's reporting the incident. According to the results of the investigation, there was no follow-up discipline for the contract facility staff involved. During the audit period, the facility had seven allegations, four allegations were sexual abuse incidents claiming inappropriate pat-searches involving contract facility. All contract staff were immediately reassigned to a post removed from detainee contact, until the outcome of the investigation. As part of the on-site portion of the Audit, the Lead Auditor reviewed a seventh allegation of sexual misconduct by contract staff. As with the other six investigations reviewed, the contract staff person was immediately reassigned to a post removed from detainee contact, until the outcome of the investigation period. Based on the findings of "unsubstantiated," there were no files to review in which a termination was warranted.

Does Not Meet: In review of 16 allegations of sexual abuse investigations, the Lead Auditor confirmed that, in two of the cases, the contract facility staff failed to promptly report and document an incident of sexual abuse as required by subpart (b) of the standard. In one of the incidents reviewed, the facility terminated the contract facility staff member; however, in the second and most recent incident, the facility took no action against the contract facility staff member for failing to report, and immediately document the incident when reported to him by the detainee. Facility contract staff are subject to disciplinary or adverse action up to and including removal from their position for violating agency or facility sexual abuse policies. The facility must provide examples of staff disciplinary or termination of staff who has engaged in sexual abuse or for violating the agency of facility's sexual abuse policies, if applicable during the CAP period. The facility must also provide and document refresher training to the appropriate staff, on the disciplinary or adverse actions for staff for substantiated allegations of sexual abuse, or for violating agency or facility sexual abuse policies for compliance review. This training documentation must be provided to the Auditor for compliance review.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f): Policy KRO/20.3.1 Disciplinary System states that "a detainee 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 the policy. The policy outlines the established limits for each offense, including sexual abuse." Per KRO/20.3.1, "any sanction imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform to rules and regulations in the future. If a detainee is determined mentally disabled or mentally ill, but competent, the 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. This process is completed by mental health staff." Per KRO/20.2.11, "KSPC 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 the investigation does not establish evidence sufficient to substantiate the allegation." The policy also outlines the facility's disciplinary system which incorporates progressive levels of reviews, appeals, procedures, and documentation procedure. The Lead Auditor reviewed nine substantiated detainee-on-detainee completed disciplinary cases of sexual misconduct reported during the audit period and determined that all but one of the perpetrators, in substantiated cases, were disciplined in accordance with the standard. An interview with the OIC further confirmed all elements of the standard are followed, regarding disciplinary sanctions of detainees. Based on the review of nine substantiated sexual abuse allegations, where all but one investigation met the standard in all material ways, the Lead Auditor has determined that the standard has been substantially met.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Standard 115.81 states that "if the assessment pursuant to 115.41 indicates the detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. In addition, the detainee shall receive a health evaluation no later than two working days from the date of the assessment and when a referral for mental health is indicated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." Interviews with medical and mental health care staff confirmed, if a referral for medical follow-up is initiated for a detainee who reported a sexual abuse history, the detainee will receive a health care evaluation no later than 2 working days from the initial assessment and if a referral for mental health follow-up is initiated, the detainee will receive a mental health evaluation no later than 72 hours. Interviews with intake processing staff and medical staff assigned to intake, confirm that detainees, who are known detainee on detainee abusers on intake, are not referred to mental health for possible treatment, nor are they offered medical treatment if appropriate. In an interview with mental health staff, the Lead Auditor confirmed that they are not provided the names of known abusers and therefore, they are not seen. During the on-site portion of the Audit, medical staff who perform intake screening noted that they had not had a detainee report a history of sexual abuse in over five years. Mental Health staff reported during an on-site interview that they would not share, with need-to-know staff, whether a detainee reported a sexual abuse history to mental health staff.

Does Not Meet: Interviews with medical and mental health staff confirmed that detainees, who perpetrated sexual abuse, are not referred for medical or mental health evaluation, as required by the standard. Per medical staff interviewed, detainees who perpetrate sexual abuse will only be seen by medical in instances where physical injury is apparent. Mental health staff confirmed that they are not provided the names of known abusers and therefore, they are not seen by mental health. The facility must develop a process to ensure that the intake and medical staff, completing the risk assessments, refer a detainee that has experienced prior sexual victimization or perpetrated sexual abuse to a qualified medical or mental health practitioner, for medical and/or mental health follow-up as appropriate. The intake and medical staff who complete risk assessments must be trained on the referral process and training documented. The facility must provide risk assessment and follow-up medical and/or mental health notes for 10 detainees that have experienced prior sexual victimization or perpetrated sexual abuse and documented staff training for compliance review, if applicable during the CAP period.

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

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

Notes:

(a)(b): Policy KRO/20.2.11 states "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." An interview conducted with a detainee who reported sexual abuse stated he received appropriate services while at the facility in a timely manner. However, a review of a detainee's mental health record indicated that one detainee requested a forensic exam due to his belief that he was raped the night before; however, there was no record of the detainee being sent to Jackson Memorial Hospital. They do note, however, the detainee's mental health status and provided mental health support as needed. According to the PAQ and submitted documentation, the facility has not had to send a detainee to Jackson Memorial Hospital to receive emergency medical assistance for sexual assault related injuries or treatment during the audit period. Interviews with medical staff confirmed detainees would receive timely emergency access to medical and mental treatment without financial cost to the detainee and would have unimpeded access to emergency medical and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. Medical staff further acknowledge that victims of sexual abuse would undergo a forensic medical exam at no cost to the detainee and only with consent of the detainee.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy KRO/20.2.11 states that "KSPC shall offer ongoing medical and mental health care for sexual abuse victims and abusers and that the facility shall offer a medical and mental health evaluation, and, 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." Both the medical and mental health staff interviews confirmed that detainee treatment is immediate, based on their professional opinion, and consistent with community level of care, including additional follow-up if necessary. 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 medical and mental health files submitted for review indicted that medical and mental health services were offered to the victim but did not elaborate on the services or if follow-up services were provided. Regarding the detainee who perpetrated sexual abuse, an interview with medical staff indicated that the abuser would be seen by medical, if there is any indication of injury. In an interview with mental health staff, the Lead Auditor confirmed that they are not given the names of known abusers upon intake and therefore, they are not seen. The Lead Auditor's review of mental health records, submitted by the facility, of both detainee victims and their known abusers, indicated that, despite mental health staff knowledge of the abuser's identity as reported to them by the victim, there was no attempt to offer treatment. In addition, interviews with intake processing staff and medical staff assigned to do intake risk assessments, confirm that detainees, who are known detainee on detainee abusers on intake, are not referred to mental health for possible treatment.

(d): Policy KRO/20.2.11 states "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." It should be noted, KNSPC does not house female detainees. Interviews with medical staff confirmed all the requirements of KRO/20.2.11 with the exception of the standard requirement that when necessary, referrals for continued care following a detainee/victim transfer to, placement in, or release from custody.

(e): Policy KRO/20.2.11 states "detainee victims of sexual abuse, while detained, shall be offered tests for sexually transmitted infections as medically appropriate." Interview with medical staff confirmed detainee victims of sexual abuse are offered tests for sexually transmitted infections and as

medically appropriate. During an interview with medical staff it was confirmed that there were no detainees who required the above-mentioned treatments during the audit period.

(f): Policy KRO/20.2.11 states "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 facility shall provide such victims with medical and mental health services consistent with the community level of care." In review of 16 completed sexual abuse investigations during the audit period and interviews with medical staff, the Lead Auditor determined detainees receive appropriate treatment, if needed, and free of financial cost per the standards requirement. An interview with a detainee who reported sexual abuse further corroborated he received appropriate treatment and at no financial cost.

(g): KRO/20.2.11 states "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." An interview with mental health staff confirmed an attempt would be made to conduct a mental health evaluation of a known detainee abuser within 60 calendar days or sooner of learning of such abuse history and offer treatment deemed appropriate, however, she further indicated that they are not given the names of known abusers; and therefore, they are not seen. The Lead Auditor's review of mental health records submitted by the facility of both detainee victims and their known abusers indicated that despite mental health staff knowledge of the abuser's identity as reported to them by the victim, there was no attempt to offer treatment. In addition, interviews with intake processing staff and medical staff assigned to do intake, confirm that detainees who are known detainee-on-detainee abusers on intake, are not referred to mental health for possible treatment.

Does Not Meet: Interviews with mental health staff, intake staff, and medical staff assigned to complete intake processing confirmed that known detainee-on-detainee abusers are not referred at intake to mental health staff for possible treatment upon intake. In addition, the Lead Auditor's review of mental health records, submitted by the facility of both detainee victims and their known abusers, indicated that despite mental health staff's knowledge of the abuser's identity as reported to them by the victim, there was no attempt to offer the abuser treatment. The facility must develop a process to ensure that intake and medical staff completing risk assessments, refer a known detainee-on-detainee abusers and facility staff refer identified abusers of a substantiated allegation to mental health to offer treatment where deemed appropriate by mental health practitioners. The intake and medical staff who complete risk assessments and other appropriate staff must be trained on the referral process of known detainee-on-detainee abusers and the completed staff training is documented. The facility must provide documentation of referrals and follow-up medical and/or mental health notes for five detainees that are known detainee on detainee abusers (if applicable during the CAP process) and documentation of staff training completed for compliance review.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b)(c) Policy KRO/20.2.11 states that "KNSPC shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The review team will also consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or gender non-conforming identification, status; or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility shall implement the recommendations or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the FOD or his or her designee, for transmission to the ICE PSA Coordinator. The facility shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator." Policy further states, and corroborated by the Lead Auditor's review of the facility's annual report that the facility" "conducts an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts, including preparation of a negative report if the facility does not have any reports of sexual abuse during the reporting year." Interviews with the OIC and PSA Compliance Manager corroborated the above-mentioned policy. The facility provided sexual abuse incident reviews for the Lead Auditor to review prior to the remote interview process and during the on-site portion of the audit. Upon review, the Lead Auditor found the sexual abuse incident reviews are completed per the standards requirements; however, in all the cases reviewed the sexual abuse incident reviews were conducted only by the two investigators that were involved in the investigations of the alleged PREA sexual assault allegations.

Recommendation: The Lead Auditor recommends that the incident review team consist of staff other than the investigators so that individuals not involved in the case are reviewing the allegations and making recommendations that could effect changes in facility policy and procedure.

§115.87 - Data collection.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Policy KRO/20.2.11 states that "the facility shall maintain a secure area where all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be maintained in appropriate files in accordance with these detention policies, and retained in accordance with established schedules." The PSA Compliance Manager confirmed the facility maintains these documents locked in his office with access on a need-to-know basis only. However, a review of 22 detainee files (12 detention files and 10 A-files), by the Audit team, confirmed that the Investigative Findings and Responsive Actions Notifications are also filed in the detainee's detention file as directed on the notification form, which is accessible to all employees and therefore, available to more than those with a need-to know basis.

Does Not Meet: A review of 12 detention files confirmed that the Investigative Findings and Responsive Actions Notifications are inappropriately filed in the detainees' detention file making the form accessible to all employees, including facility staff and not maintained in a secure area. Per direction provided on the form, it is to be filed in the investigative file. The facility must develop a plan or directive to maintain all case records associated with allegations of sexual abuse in the appropriate files to ensure security of the information and develop a secure area to maintain all sexual abuse case records. This plan and the location of the secure case records must be shared with the Auditor for compliance review.

§115.201 - Scope of audits.

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

Notes:

(d)(e)(i)(j) During the Pre-Audit and Remote Interview phases of the audit, the Auditors were unable to review all policies, memos, and other documents required to make assessments on PREA compliance due to the facility not submitting needed documentation requested by the Lead Auditor or submitting incomplete documentation. However, the facility was able to provide needed documentation as requested during the on-site portion of the audit and afforded the Audit team access to all areas of the facility and a private area to interview additional detainees. The Auditor received no detainee correspondence prior to, or during, the onsite portion of the audit.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	24
Number of standards not met:	16
Number of standards N/A:	1
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.

Sabina A. Kaplan 6/2/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 6/2/2021

PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 6/2/2021

Assistant PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Sabina Kaplan	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	914-474-[redacted]
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-597-[redacted]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Miami Field Office		
Field Office Director:	Michael W. Meade		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	18201 SW 12th Street, Miami Florida 33194		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Krome North Service Processing Center		
Physical address:	18201 SW 12th Street, Miami Florida 33194		
Mailing address: *(if different from above)*			
Telephone number:	(305) 207-2001		
Facility type:	SPC		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	305-207-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6)	**Title:**	Senior Detention Officer
Email address:	(b) (5), (b) (7)(C)	**Telephone number:**	(305) 207-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) audit of Krome North Service Processing Center (KNSPC) was conducted on January 27 – 29, 2021 by Sabina Kaplan, U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor for Creative Corrections, LLC of Beaumont, Texas. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) and Assistant Program Manager, (b) (6), (b) (7)(C), DOJ and DHS certified PREA Auditors.

The KNSPC is owned and operated by U.S. Immigration and Customs Enforcement (ICE). Security services are provided by Akima Global Services (AGS). The facility processes detainees who are pending immigration review or deportation. The purpose of the January 2021 audit was to determine compliance with DHS PREA Standards. This was the second DHS PREA audit of the facility. The incorporation date for the KNSPC was May 29, 2015. The audit review period included 18 months from July 2019 through January 2021. Upon completion of the audit, the KNSPC was found to be non-compliant with 16 standards.

In total, the facility had 24 standards that Met, 0 standards that Exceed, 16 standards that Did Not Meet, and 1 standard that was Non-Applicable.

Standards that Did Not Meet

§115.13 – Detainee supervision and monitoring
§115.15 – Limits to cross-gender viewing and searches
§115.16 – Accommodating detainees with disabilities and detainees who are limited English proficient
§115.31 – Staff Training
§115.32 – Other Training
§115.33 – Detainee education §115.41 - Assessment or risk of victimization and abusiveness
§115.42 – Use of assessment information
§115.51 – Detainee Reporting
§115.52 – Grievances
§115.61 – Staff and agency reporting duties
§115.67 – Agency protection against retaliation
§115.77 – Corrective action for contractors and volunteers
§115.81 – Medical and mental health screenings; history of sexual abuse
§115.83 – Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 – Data Collection

The Corrective Action Plan (CAP) period review was assigned to Sabina Kaplan, DOJ and DHS PREA Auditor and Assistant Program Manager, contracted through Creative Corrections, LLC, for those standards found to be deficient during the facility's January PREA audit. The Agency provided the Auditor the 180 Day CAP in July 2021, which was reviewed by the Auditor who provided responses to the proposed corrective actions. The 180-day CAP process began on June 8, 2021, with an ending date of December 8, 2021. The facility submitted documentation for the corrective action process on November 18, 2021, through December 6, 2021. In a review of the submitted documentation to demonstrate compliance with the deficient standards, the Auditor determined compliance with five of the standards and found that 11 standards still did not meet based on submitted documentation or lack thereof. The facility's full compliance with standard 115.15 (g) was contingent on facility observations during a CAP reinspection on-site visit, and one was scheduled for December 14, 2021, to verify full compliance with standard 115.15 (g) through on-site observation.

Before the start of the CAP reinspection site visit, the Auditor met with agency and facility staff. The Team Lead opened the entry briefing at 8:30 am, via a conference call, on the first day of the on-site re-visit. In attendance were:

(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU (Via Conference Call)
(b) (6), (b) (7)(C) ERO Miami Assistant Field Office Director
(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer, ICE/ERO
(b) (6), (b) (7)(C) APM, AGS KNSPC
(b) (6) Quality Assurance Manager (QAM), AGS KNSPC

The Lead Auditor opened the meeting by thanking the staff for the documentation provided during the CAP period. Brief introductions were made, and the Auditor discussed the on-site re-audit tour. The Lead Auditor provided an overview of the CAP reinspection on-site visit process and the methodology used to determine PREA compliance. The Lead Auditor also stated compliance with PREA standard 115.15 (g) will be determined by observations made during the facility tour and any additional on-site documentation review that may be needed.

A tour of the noted areas with cross gender viewing issues was completed by the Lead Auditor and key facility staff. Areas re-visited included Visitation Rooms 1, 2, and 3; the out-processing changing room; the IHSC medical cells 1 and 2; the infirmary cells 7, 9, and 10; medical isolation rooms 3, 4, 5, and 6; mental health patient rooms 1 and 4; the Special Management Unit; and the Krome Behavioral Health Unit (KBHU). In addition to touring these areas, the Lead Auditor visited the Control Centers and reviewed the cameras associated with the cross-gender viewing issues noted in the final PREA report issued for KNSPC.

The facility waived the Exit briefing upon the conclusion of the tour; however, the Lead Auditor explained to the SDDO, APM, and QAM that a final finding for each deficient standard could not be determined until the Auditor reviewed all information/documentation gathered during the CAP process and observations made during the facility on-site re-visit. Staff were professional and cooperative. The Lead Auditor thanked the staff for the hospitality and cooperation provided throughout the on-site re-visit.

This report is a final report based on the documentation that was submitted for review during the CAP period and information gathered during the on-site visit, for those standards found to be deficient during the facility's PREA audit in January 2021. The report is being completed to detail the facility's current compliance status with the previous 16 deficient standards noted on the final report.

Meets Standard (4):

§115.16 – Accommodating detainees with disabilities and detainees who are limited English proficient
§115.33 – Detainee education
§115.52 – Grievances
§115.87 – Data Collection

The following standards that still Do Not Meet: (12)

§115.13 – Detainee supervision and monitoring
§115.15 – Limits to cross-gender viewing and searches
§115.31 – Staff Training
§115.32 – Other Training
§115.41 – Assessment or risk of victimization and abusiveness
§115.42 – Use of assessment information
§115.51 – Detainee Reporting
§115.61 – Staff and agency reporting duties
§115.67 – Agency protection against retaliation
§115.77 – Corrective action for contractors and volunteers
§115.81 – Medical and mental health screenings; history of sexual abuse
§115.83 – Ongoing medical and mental health care for sexual abuse victims and abusers

PROVISIONS

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

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

(c): Meeting minutes supplied to the Lead Auditor in conjunction with the change from three shifts to two shifts in July of 2020 confirmed that, during the modification of on-site supervision, the facility did not take into consideration any judicial findings of inadequacy, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, or the findings and recommendations of sexual abuse incident review reports in evaluating whether the change in supervision will affect the facility's efforts to prevent sexual abuse. The interview with the OIC further confirmed that the number of staff is determined by the physical plant layout, the size of the facility, and the composition of the detainee population.

Does Not Meet (c): Per subpart (c) of standard 115.13, "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, or the findings and recommendations of sexual abuse incident review reports, and any other relevant findings, including the length of time detainees spend in agency custody." Documentation submitted, in addition to the interview of the OIC, confirms that, during the last restructuring of line supervision, the facility did not take into consideration any judicial findings of inadequacy, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, or the findings and recommendations of sexual abuse incident review reports in evaluating whether the change in supervision would affect the facility's efforts to prevent sexual abuse. The facility must document that the standard elements of subpart (c) are taken into consideration during the review of supervision guidelines for compliance.

Corrective Action Taken (c): The facility provided the Auditor with Partner's Meeting Minutes dated 11/5/20. The minutes do not contain any of the elements required by subparagraph (c), which must be considered by the facility when they are conducting the annual review of the facility staffing plan. The facility does not comply with standard 115.15(c).

§115. 15 - Limits to cross-gender viewing and searches
Outcome: Does not Meet Standard
Notes:

(g): The facility's policy 20.030 Personal Hygiene states that "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." Policy 20.030 also states "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." Interviews with detainees, and facility staff, also confirmed the detainees have privacy for these functions. During the interviews, female facility staff indicated they announce themselves when entering an area by announcing "female on deck." Detainees interviewed stated they did recall opposite gender staff announcing themselves on a regular basis. During the on-site portion of the tour the Auditors observed female facility staff announcing themselves as required by policy. However, during the on-site portion of the audit, the Auditors observed the following opposite gender viewing issues throughout the facility: the holding cells dedicated to Pods 2, 3, and 6 in the visitation area had toilets visible to staff of the opposite gender; the out-processing changing room was visible on the control center camera and a female was staffed in the area; the IHSC medical screening area holding cells toilets could be viewed by the opposite gender staff; medical cells 1 and 2 toilets could be viewed by opposite gender staff; the infirmary rooms 7, 9, and 10 and the medical isolation rooms 3, 4, 5, and 6 toilets and showers could be viewed by the opposite gender staff and were also visible on camera by opposite gender staff; patient rooms 1 and 4 had toilet cell toilets could be viewed by opposite gender staff; the mental health rooms 1, and 4 toilets could be viewed by opposite gender staff and were also visible on camera by opposite gender staff; and the cells in the SMU had changing viewing issues as they were visible on camera by opposite gender staff. In addition, the detainee bathroom in the Krome Behavioral Health Unit (KBHU) was not secured, or controlled by facility staff, allowing the detainees to enter at will and the handicapped shower could be viewed by opposite-gender staff. Building 8 housing unit had similar opposite gender viewing is issues, however, the facility provided the Lead Auditor with a shift roster, on-site, confirming the area was supervised by male-only posts.

Does Not Meet (g): (b) (7)(E) [redacted]

Corrective Action Taken (g): On December 12/14/21, the Lead Auditor revisited the KNPSC to observe those areas that were found to have cross gender viewing issues. Based on observation the Lead Auditor determined that the following areas were now compliant. The holding cells dedicated to Pods 2, 3, and 6 in the visitation area had been appropriately frosted. The out-processing changing room was no longer visible on the control center camera. In SMU, the facility had instituted a policy that allowed detainees the option to dress in the shower area instead of in their cell; however, it should be noted that although signs were posted in three areas of the SMU in English, Spanish, and Creole, it was not available in other languages. The PCM indicated that the detainees were advised during placement in SMU of the new policy; however, upon follow-up with the PCM, the Lead Auditor determined that the facility had no formal procedure in place to document that the detainees received the information. In addition, during the on-site revisit of KNSPC, the Lead Auditor observed a staff member with the aforementioned signage, and upon questioning, she indicated she was in the process of posting the information in all the cells. The Lead Auditor was also advised that the SMU camera posts will eventually become all male posts, but the change was in transition and will take some time to become policy. The last area to become compliant was the Krome Behavioral Health Unit (KBHU). The hallway entrance was now visible on the officer's station cameras, and the door window was frosted allowing viewing only during routine cell checks. In contrast, the following areas continued to have cross gender viewing issues as noted in the KNSPC report: the IHSC medical screening area holding cells toilets could be viewed by the opposite gender staff; medical cells 1 and 2 toilets could be viewed by opposite gender staff; the infirmary rooms 7, 9, and 10 and the medical isolation rooms 3, 4, 5, and 6 toilets could be viewed by the opposite gender staff and were also visible on camera by opposite gender staff; patient rooms 1 and 4 cell toilets could be viewed by opposite gender staff; the mental health rooms 1, and 4 toilets could be viewed by opposite gender staff and were also visible on camera by opposite gender staff. The PCM indicated that they had requested and received approval to add half curtains around the toilet areas; however, the funding has not been received. The Lead Auditor requested information confirming the funding was approved and when; however, the facility failed to provide the recommended documentation. The facility does not comply with 115.15 (g).

§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): Policy KRO/20.2.11 (SAAPI) dictates that "the detainee PREA notification, orientation, and instruction be in a language or manner 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, therefore guaranteeing that detainees with disabilities and detainees with limited English proficiency (LEP) have an opportunity to participate in and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment." Upon intake, detainees, as required by KRO/20.2.11, are to be provided with the ICE National Detainee Handbook, available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese) and the facility's Detainee Handbook Local Supplement to the ICE National Detainee Handbook, available in English, Spanish and Creole only. Both handbooks provide detainees with information on the agency and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse, as well as information on detainees' rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS. The medical staff advised if a detainee coming through intake spoke a language that was not available in a written format, they would utilize an interpretive service, Lionbridge. The Intake Supervisor interviewed stated the detainees are provided written materials in a language they understand through the handbooks, and the language line, U.S. Citizenship, and Immigration Services (USCIS), when needed for interpretation. In the 16 allegation investigations reviewed, the Lead Auditor determined the facility used facility staff interpreters and did not utilize another resident to interpret during the investigations. The Audit team also reviewed 10 detainee A-files and 12 detainee detention files, and although the files contained a preferred language form, all the preferred language forms submitted with the files were incomplete and did not clearly indicate how language assistance was provided to the detainee. In addition, the documentation reviewed in all 22 detainee files was unclear as to what handbook the detainee received, ICE or facility, nor was it clear from the documentation what language handbook(s) was given to the detainee. Interviews with detainees housed at KNSPC during the remote interview phase, and during the on-site portion of the audit who were LEP, indicated they rely heavily on other detainees to understand what is being stated by facility staff. In addition, the review of 12 detainee detention files during the on-site portion of the Audit confirmed that detainees who spoke languages other than English or Spanish consistently were documented of wanting the English facility's Detainee Handbook Local Supplement by choice. There was no documentation to confirm the detainees received the additional ICE National Detainee Handbook in their preferred language. Interviews with facility staff confirmed there is an available language line; however, none of the interviewees, with the exception of the supervisor of the intake area, were clear as to how the language line was used.

During the on-site portion of the audit, the Audit team observed the in-processing of a detainee. The detainee was Spanish speaking and a Spanish speaking facility staff provided interpretation; however, it was noted by the Auditors that the preferred language form was filled out prior to the detainee being in-processed. In addition, the detainee was not provided with the ICE National Detainee Handbook. The detainee received the facility's Detainee Handbook Local Supplement; however, the facility staff member did not cover the PREA information with the detainee. The Audit team further observed, during the facility tour, that there was only one available phone that was dedicated as the language line. Upon discussing, with the intake area line supervisor, what would happen if they received their average intake of 50 detainees and there was an overwhelming need to provide language line services, the intake area line supervisor was not clear as to how this service would be provided to more than one detainee. In addition to the detainees who indicated that they did not receive a copy of the facility's Detainee Handbook Local Supplement during the contingency phase of the audit, the Audit team informally interviewed seven random detainees regarding whether or not they received the ICE National Detainee Handbook. Only one of the detainees interviewed indicated that he had received the ICE National Detainee Handbook; this detainee was English speaking. In addition, the facility did not provide the Auditors during the remote interview phase, or during the on-site portion of the audit, with clarification regarding how a detainee with a disability, such as blindness or deafness, is aided in understanding the PREA information provided at intake. During the on-site portion of the audit, the Audit team observed the orientation video that is played at intake processing. The video is closed-captioned; however, the volume was extremely low making it difficult for the visually impaired to receive and understand the information.

Does Not Meet (a)(b): The Audit team observed the in-processing of a Spanish speaking detainee, who was provided with interpretation services through a facility staff member during intake, however the form documenting interpretation services was filled out prior to the detainee actual arriving and confirming his language preference upon arrival. In addition, the detainee was not provided the ICE National Detainee Handbook which contains important PREA information for LEP detainees who do not understand the languages the facility's Detainee Handbook Local Supplement is available in. The facility's Detainee Handbook Local Supplement is only available in English, Spanish, or Creole. Informal interviews with random detainees confirmed that they did not receive the ICE National Detainee Handbook. In addition, interviews with facility staff did not confirm whether each LEP detainee is provided the proper interpretation services needed through the language line nor did they confirm whether LEP detainees would receive both the ICE National Detainee Handbook and the facility's Detainee Handbook Local Supplement upon intake. For compliance, the facility must demonstrate how LEP detainees are provided the PREA information in a manner they understand, and all detainees receive an ICE National Detainee Handbook in a language they understand, if available, or document how the information is provided to them through another method. The facility must provide 10 LEP detainee files documenting that the PREA information was provided to the detainee in a manner they understand. The documentation must demonstrate a variety of languages, other than English and Spanish over a month period.

Corrective Action Taken (a)(b): As requested, the facility submitted documentation that the Intake staff were trained on the proper use of the language line. In addition, the facility provided the Lead Auditor with 10 detainee files that included detainees who spoke other languages than English or Spanish. All files submitted met the requirements of subsections (a)(b) of the standard. The facility is in compliance with Standard 115.16 (a)(b).

§115. 31 - Staff training
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): Policy KRO/20.2.11 outlines how the facility trains all employees who may have contact with detainees, and for all facility staff to be able to fulfill their responsibilities and includes each element of the standard. The policy dictates that "training on the facility's SAAPI Program shall be included in training for all new employees and shall also be included in annual refresher/in-service training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards." The Auditor reviewed the KNSPC PREA training curriculum and determined it to be compliant with the standard in all material ways. The Auditor randomly selected six facility staff files and reviewed training documentation for proof of completion and determined the training was compliant per the standard's requirement, to include by the facility's PREA incorporation date. Staff training documentation is maintained within employee training files. Interviews with the Training Supervisor confirmed the facility staff have received the required PREA training and refresher training. Facility staff receive the same level of PREA comprehensive training annually, exceeding the requirement of the standard, which calls for refresher training every two years. However, the Lead Auditor further reviewed the training files of five ICE staff, who have contact with detainees, and four of the training files confirmed that PREA training was not provided in accordance with the standard. Two ICE staff members had not received PREA training since 2016 and 2018 respectively, and two ICE staff members had not received PREA training at any time.

Does Not Meet (b)(c): The Lead Auditor reviewed five training files of ICE staff who have contact with detainees and confirmed that four of the five files reviewed were not compliant with the standard, that requires "the agency to train or require the training of all employees who may have contact with detainees, and all facility staff, to be able to fulfill their

responsibilities under this part." For compliance all ICE staff who have contact with detainees must receive PREA training and the training documented by the facility. The Auditor will select and request five ICE staff training files for compliance review.

Corrective Action Taken (b)(c): The facility failed to provide the Auditor with a listing of all ICE employees in a timely fashion. As an alternative, the facility provided a listing of staff who completed the Annual PREA training in 2021. The training documentation submitted confirms that 12 out of 45 (1/3) of ICE personnel did not attend the 2021 PREA training scheduled for 5/4/21. The facility does not comply with standard 115.31 sub-sections (b) and (c).

§115. 32 - Other training
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): Policy KRO/20.2.11 outlines how "the facility shall train, or require the training of, all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard." Per the policy, KNSPC will ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The policy further states that "the level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed on how to report such incidents." In review of the training curriculum, the Auditor determined all the required elements of the standard are covered and the curriculum meets the level and type of training required for volunteers who may have contact with detainees. Submitted with the facility PAQ was supporting documentation of completed training for volunteers, including signed acknowledgments of training received and training session sign-in sheets. The Lead Auditor interviewed the facility's Chaplain, who is responsible for conducting volunteer training, and the Second Auditor reviewed five volunteer training records on-site and determined all volunteers received the required training. In addition, while on-site, the Lead Auditor reviewed three training files for contractors, who provide services at KNSPC and have contact with detainees. The Auditor's review confirmed that none of the contractors received PREA training. The Lead Auditor further interviewed the Assistant Program Manager (APM), responsible for contractors, who confirmed that the contractors had not received the training as required by the standard and that there was no procedure in place to provide the training.

Does Not Meet (a)(b)(c): The Lead Auditor reviewed three contractor files who have contact with detainees and interviewed the Assistant Program Manager responsible for contractors and confirmed that KNSPC does not have a procedure in place to train contractors who provide services to KNSPC and have contact with detainees, as required by the standard. For compliance, the facility must complete and document PREA training for all contractors. The facility must submit a list of contractors to the Auditor to select five random training files for compliance.

Corrective Action Taken (a)(b)(c): The facility did not provide the Lead Auditor with a listing of all contractor staff as requested. According to the PAQ, the facility contracts with medical, food service, maintenance, and religious services. Training documentation submitted is noted to be given to Detention Management, Transportation, and Food Service. Documentation of contractor staff receiving training confirms 22 listed contractors in these three categories did not receive PREA training for 2021. The facility does not comply with standard 115.32 sub-sections (a), (b), and (c).

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

(a)(c)(e)(f): Policy KRO/20.2.11 indicates that "following the intake process, KNSPC shall provide instruction to detainees on the KNSPC's SAAPI Program and ensure that the instruction includes KNSPC's zero-tolerance policy for all forms of sexual abuse." Documentation submitted with the PAQ indicates that PREA information was provided to detainees through the DHS-prescribed Sexual Assault Awareness Information pamphlet, DHS posted signage "ICE Zero-Tolerance," the ICE National Detainee Handbook, and the local facility's Detainee Handbook Local Supplement to the ICE National Detainee Handbook. The Audit team reviewed Detainee Summary Forms contained in 10 detainee Alien files (A-files) and 12 detainee's detention files, which were signed by the detainees, indicating that they had a question-and-answer session conducted with them concerning the handbooks, DHS-prescribed Sexual Assault Awareness Information pamphlet, and an orientation video. However, during the on-site portion of the audit, the Audit team observed the intake processing of a detainee that, although the facility staff had the detainee sign this section of the Detainee Language and Communication Assistance form, the detainee was not advised of any of the above. The Audit team observed the facility staff person simply hand the detainee a facility's Detainee Handbook Local Supplement. The detainee was then told to sit in a holding cell, where the orientation video was playing above him, in a language he did not understand, with the sound inaudible. The Audit team also observed another detainee in a holding cell, who was told to sit under the tv playing the orientation video, however the sound inaudible. When the Audit team requested that the video be played at an audible level, facility staff had

difficulty finding the remote control to turn up the volume. In addition, the detainee remained in the holding tank for a minimal period of time, which did not allow him to view the orientation video in its entirety. Further, upon observation in the other holding cells, the Audit team determined the sound was inaudible in all the cells. The detainee observed during the intake process was not given a DHS-prescribed Sexual Assault Awareness Information pamphlet; intake staff indicated that it was incorporated into the facility's Detainee Handbook Local Supplement; however, he was not advised that the PREA information existed in the handbook or where he could find it. In addition, the detainee was not supplied with a copy of the ICE National Detainee Handbook. During the Auditors review of the 22 detainee files, there was a detainee signed receipt of a handbook(s); however, the files were illegible in determining which handbook(s) the detainee actually signed that was received. Although the Detainee Language and Communication Assistance form provides a way to document the assistance for LEP detainees, of the 12 detainee files and 10 detainee A-files reviewed by the Lead Auditor, none of the Detainee Language and Communication Assistance forms were properly filled out; and therefore, cannot be used to determine standard compliance**.**

Does Not Meet (a)(c)(e)(f): The Lead Auditor, through both interviews and on-site observation determined that the PREA information is not provided to detainees as required by subparts (a, c, e, and f) of the standard. Although the facility has the detainee sign a Detainee Summary Form as required by subpart (c) of the standard, the form does not reflect what actually occurs during the intake process. While observing a detainee's intake processing, the Audit team confirmed that facility staff did not provide or discuss PREA information including zero-tolerance policy, provide the detainee with the ICE National Detainee Handbook, inform the detainee of PREA information including that the DHS-prescribed Sexual Assault Awareness Information pamphlet was in the facility's Detainee Handbook Local Supplement, and did not provide the detainee an opportunity to view the Spanish Orientation Video, which included PREA information, at any time during the intake process. The detainee, by virtue of receiving the local facility's Detainee Handbook Local Supplement, received a copy of the DHS-prescribed Sexual Assault Awareness Information Pamphlet. The facility must ensure that detainees are informed about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse that addresses standard elements in (a) and document the process properly. The PREA orientation must be provided in a language or manner the detainee understands and documented to demonstrate compliance. The Auditor will request intake lists from various days to select random detainees to review their files for compliance on the PREA education orientation process.

Corrective Action Taken (a)(c)(e)(f): The Auditor requested 10 detainee files for detainees who were not English or Spanish speaking to confirm that the detainee completed the orientation process in a language that they understood. The facility provided the detainee files, and the Auditor was able to confirm the detainee received the information in a language they understood. The facility is in compliance with Standard 115.33 (a)(c)(e)(f).

(b) Policy KRO/20.2.11 states detainee orientation and instruction must be in a language, or manner that the detainee understands, including for those who are LEP, deaf, visually impaired, otherwise disabled, as well as to detainees who have limited reading skills. The ICE National Detainee Handbook is available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). Of the 39 detainees interviewed by the Second Auditor, only a few detainees were aware of the zero-tolerance policy at KNSPC, and most detainees were unfamiliar with the subject of PREA in general. During the on-site portion of the Audit, the Lead Auditor was advised by the Intake Supervisor that while the facility's Detainee Handbook Local Supplement was available in English, Spanish, and Creole only, detainees receive an ICE National Detainee Handbook in their language of choice to supplement the facility's Detainee Handbook Local Supplement. During the on-site tour, the Audit team confirmed, through observation of an intake processing, that not all detainees receive an ICE National Detainee Handbook or one in a language they understand. The Audit team, through on-site observation, confirmed that the orientation video is closed caption; however, it is only available in English, Spanish, and Creole. During the on-site portion of the Audit, the Audit team, through interviews with intake processing facility staff could not confirm how the facility provides the PREA education to those detainees who are LEP and speak another language not covered by the orientation video, deaf, visibly impaired, or otherwise disabled.

Does Not Meet (b): During the on-site portion of the Audit, the Audit team observed the intake processing of a detainee. By observing this process, the Audit team confirmed that the facility does not meet subpart (b) of the standard. The detainee was not afforded the opportunity to watch the orientation video in his preferred language, Spanish, nor was he provided with an ICE Detainee National Handbook in Spanish. Although the video was closed captioned, in an interview with the Intake Supervisor, the Lead Auditor was not provided a clear policy regarding how the facility would provide this information to a detainee who was visually impaired or otherwise disabled, who had limited reading skills, or who spoke a language other than English, Spanish, or Creole. The facility must ensure detainees are provided an orientation program in a language or manner the detainee understands and informs the detainee about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse and addresses each standard element in (a). This facility must document the orientation process of each detainee. The Auditor will request a detainee intake list from various days to select random LEP

detainees and detainees with disabilities to review the detainee files for the PREA orientation process in a manner the detainee understands for standard compliance.

Corrective Action Taken (b): The Auditor requested that the facility provide a post order to include direction for all intake staff to maintain the volume of the orientation video at a level that can be heard by all detainees during the intake process. The facility provided a post order directed to Processing Officer One, dated 11/4/2021, that directs staff to "ensure that the DHS/ICE Detainee Orientation video will play at an adequate volume level so that detainees in the cell can hear all the information clearly, including the PREA segment, consecutively throughout the time newly arriving detainees are held in all Processing Holding Cells." In addition, the Auditor requested 10 detainee files for detainees who were not English or Spanish Speaking to confirm that the detainee completed the orientation process in a language that they understood. The facility provided the detainee files, and the Auditor was able to confirm the detainee received the information in a language they understood. The facility is in compliance with Standard 115.33 (b).

§115. 41 - Assessment or risk of victimization and abusiveness
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d): Policy KRO/20.2.11 states that "KNSPC 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 policy further states that "each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly and that the screening shall consider 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 been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as LGBTI or gender nonconforming, whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as having previously experienced sexual victimization, and the detainee's own concerns about his or her physical safety." According to interviews with the Classification Supervisor and intake staff, ICE screens detainees for special vulnerabilities prior to being transferred into the facility, which is reflected on a Risk Classification Assessment (RCA) screening form. The RCA screening takes into consideration whether the detainee has a mental, physical or developmental disability, the age of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as LGBTI or gender nonconforming, whether the detainee has any convictions for sex offenses against an adult or child, 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 RCA further considers prior convictions for violent offenses and institutional history but does not consider any prior convictions for sexual abuse. This information, along with the physical appearance of the detainee, is captured when the detainee is interviewed by medical and entered through the IHSC Intake Screening; however, it does not appear that the information is utilized in making an initial housing determination. During the contingency portion of the audit, the Lead Auditor reviewed 10 detainee A-files and determined the files lacked the completed documentation needed to meet the standard. While on site, the Audit team reviewed an additional 12 detainee files. Included in the 12 detainee files, but not the 10 A-files reviewed, was an "In-Processing Special Vulnerability Questionnaire" that according to the Intake supervisor, was developed by the facility and is used to gather detainee information upon intake. The form includes whether the detainee has a "mental, physical or developmental disability, the age of the detainee, whether the detainee has self-identified as LGBTI 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 form does not take into consideration the physical build and appearance of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, or whether the detainee has any convictions for sex offenses against an adult or child. The facility's Policy KRO/20.2.2 dictates that "the initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility." Intake staff were interviewed and confirmed the timeline for in-processing new detainees. Documentation submitted with the PAQ confirmed that not all detainees are screened upon intake. The review of a sexual abuse investigation file determined that the two involved detainees were not screened upon their arrival to KNSPC. When the facility could not provide the two detainees' intake files, they advised the Lead Auditor that they did not conduct any intake processing on either of the two detainees. In addition, of the 33 detainees interviewed, only four detainees could clearly articulate they had been screened when they arrived at KNSPC.

Does Not Meet (a)(b)(c)(d): The Lead Auditor reviewed a sexual abuse investigation file and determined that both the victim and the abuser were not screened upon arrival to KNSPC. The facility advised the Lead Auditor that the two detainees were not assigned to KNSPC. The staff indicated that the two detainees were being held over from another detention facility, due to impending bad weather, and therefore, were not afforded intake screening. The facility must assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and utilize this information for

housing determinations to prevent sexual abuse for compliance. The Auditor will request a detainee intake list from various days to select random detainees to review the detainee's risk screening was completed within 12 hours to ensure all detainees arriving at the facility have a completed risk screening.

Corrective Action Taken (a)(b)(c)(d): The Lead Auditor requested 10 detainee files to review for the timely completion of risk assessments. The facility submitted the files as requested. The review of the files determined that the facility utilized both the Risk Classification Assessment (RCA) and the In-Processing Special Vulnerability Questionnaire. Although the assessments were timely, even when combined, the two documents did not consider all elements of the standard including: the physical build and appearance of the detainee and whether the detainee has self- identified as gay, lesbian, bisexual, intersex, or gender non-conforming. Although the facility is in compliance with standard 115.41 (a)(b)(d), the facility remains non-compliant with 115.41(c).

(e): According to the Lead Auditor's interview with the Classification Supervisor, reassessment of a detainee's risk level for victimization or abusiveness is conducted by the appropriate case manager. The RCA module is also used for completing the reassessment. During the review of 10 detainee A-files and 12 detainee detention files, the Audit team found that none of the files confirmed the proper procedures are being followed per the standard. Both sets of files were incomplete and did not provide the Lead Auditor with the documentation to confirm that detainees are reassessed as mandated by the standard. Issues involving completing the reassessment during the required 60 and 90 days, in addition to not reassessing detainees following an incident of abuse or victimization was confirmed. An interview by the Lead Auditor with the APM confirmed that the facility did not reassess a detainee following an incident of abuse or victimization, nor did the classification staff interview the detainee during the reassessments.

Does Not Meet (e): The Audit team reviewed 10 detainee A-files and 12 detainee detention files and confirmed that not all detainees are being re-assessed in accordance with subpart (e) of the standard. Reviewed files confirmed that reassessments are untimely, and not completed following an incident of abuse or victimization. The Lead Auditor's interview with the APM further confirmed that reassessments are not being done in accordance with subpart (e). The facility must complete risk reassessments between 60 and 90 days from the date of the initial risk 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 Auditor will request a list of detainees housed beyond 90 days to select random detainee files for compliance review on the PREA risk assessment process and five detainee files for reassessment based upon receipt of additional, relevant information or following an incident of abuse or victimization, if applicable.

Corrective Action Taken (e): The Lead Auditor requested 10 detainee files be provided from the facility of detainees from various days and any investigative files to determine that risk assessments had been conducted following an incident of sexual abuse. The facility submitted a memo to all staff that directed staff to complete risk assessments in a timely manner and to conduct all reassessments of detainees within 60 and 90 days and whenever there is an incident of sexual abuse or when new information is received. The facility further submitted ten detainee files, one investigation file, one medical, and two mental health files for review. Of the 10 detainee files reviewed, one detainee was due for a reassessment. The file did not confirm that the reassessment was completed at the 90-day mark as required. In addition, the one investigation file, medical record, and two mental health files did not confirm that the detainee was reassessed at any point after an incident of sexual abuse as required by the standard. The facility is not in compliance with 115.41 (e).

(g): The interview with the PSA Compliance Manager indicated appropriate controls are placed on all detainee information including risk assessments and sexual abuse allegations; however, a review of 12 detention files confirmed that the Investigative Findings and Responsive Actions Notification forms are filed in the detention file, as opposed to just the detainee's A-file, as directed on the notification form. This file is accessible to all employees; and therefore, available to more than those with a need to know.

Does Not Meet (g): A review of 12 detainee detention files confirmed that the Investigative Findings and Responsive Actions Notifications are inappropriately filed in the detention file making the form accessible to all employees, including facility staff. Per direction provided on the form, this information is to be filed in the investigative file and the detainee's A-file. The facility must remove all Investigative Findings and Responsive Actions Notifications from the detention files to eliminate accessibility to all staff for compliance. The facility must also implement appropriate controls or policy directives to ensure that sensitive information is not accessible to all staff or exploited to the detainee's detriment by staff. The facility must provide a process to control accessibility of sensitive information to all staff and document the implementation of this process. A random review of the detention files will be completed to ensure sensitive information is not maintained in the detention files accessible to all staff.

Corrective Action Taken (g): The Lead Auditor requested 10 detainee files, and any available investigation files to review to confirm that the notification to detainee of the outcome of the investigation is no longer placed in the detainee file. The facility provided a memo to all staff advising the staff to no longer place the outcome notice to detainee in the detainee file. The facility also submitted one investigation file that confirmed that the notice to detainee routing information was removed from the notification form. The facility is in compliance with standard 115.41 (g)

§115. 42 - Use of assessment information
Outcome: Does not Meet Standard
Notes:

(a): Policy KRO/20.2.2 outlines how the facility uses the information obtained through the RCA tool conducted at initial screening when considering detainee housing, recreation, voluntary work programs and other activities. In review of 10 detainee A-files, the Lead Auditor determined the facility is utilizing the data collected from the RCA tool, such as the detainee's age, whether the detainee has mental, physical or development disability, previous disciplinary history, alleged offense and criminal history, whether the detainee is perceived to be LGBTI or is gender non-conforming to determine initial housing. However, the Lead Auditor could not confirm the facility utilized the detainee's physical build or prior convictions of sexual abuse in their determinations, which is captured in the IHSC Intake Screening. It does not appear that the information captured in the IHSC Intake Screening is utilized in making an initial housing determination. In addition, the detainee's files did not confirm the facility uses the information gathered pursuant to 115.41's requirements to make individual determinations regarding recreation, work, and other activity decisions. While on-site, the Audit team reviewed an additional 12 detainee files. Included in the detainee file, but not the 10 A-files reviewed, was an "In-Processing Special Vulnerability Questionnaire" that, according to the Intake supervisor, was developed by the facility and is used to gather detainee information upon intake. The form includes whether the detainee has a mental, physical, or developmental disability, the age of the detainee, whether the detainee has self-identified as LGBTI 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 form does not take into consideration the physical build and appearance of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, or whether the detainee has any convictions for sex offenses against an adult or child. The form includes a section regarding housing that includes General Population, General Population with referral to medical care, isolation after requesting protective custody, and isolation until medically evaluated; however, this section was not utilized in any of the 12 detainee files reviewed by the Audit team. In addition, the Audit team noted that a number of the vulnerability questionnaires were completed by the detainee and not the intake staff as required. During the on-site portion of the Audit, the Intake Supervisor indicated that the facility housed detainees strictly by security level, confirming that the vulnerability portion of the file is not taken into consideration when determining housing. This was observed during the housing determination of a detainee during intake. While on-site, during an interview with mental health staff, the Audit team was advised that if mental health received information that the detainee had a sexual abuse history, they would not share the information with facility staff responsible for housing, recreation, and other activities. The Lead Auditor reviewed on-site a copy of a "Voluntary Work Program, Volunteer Worker Screening Form," which did not include the intake screening information for making decisions for recreation and other activities. Interviews with the classification and intake staff, and the APM, further confirmed the facility did not utilize the assessment information, as required in the standard, to determine recreation, work, and other activity decisions.

Does Not Meet (a): The facility's "In-Processing Special Vulnerability Questionnaire" was not utilized in any of the 12 detainee files reviewed by the Audit team. The facility does not utilize the data collected from the RCA tool, such as the detainee's age, whether the detainee has mental, physical or development disability, previous disciplinary history, alleged offense, and criminal history, whether the detainee is perceived to be LGBTI or is gender non-conforming, nor the information captured in the IHSC Intake Screening in making an initial housing determination. In addition, the Intake Supervisor indicated that the facility housed detainees strictly by security level, confirming that the vulnerability portion of the file is not taken into consideration when determining housing. Mental health staff interviewed confirmed that, if mental health received information that the detainee had a sexual abuse history, they would not share the information with facility staff responsible for housing, recreation, and other activities. The Lead Auditor reviewed on-site a copy of a "Voluntary Work Program, Volunteer Worker Screening Form," which did not include the intake screening information for making decisions for recreation and other activities. Interviews with the Classification and Intake staff, and the APM, further confirmed the facility did not utilize the information as required in the standard to determine recreation, work, and other activity decisions. The facility must use the information from the risk assessment under 115.41 to make informed determinations for housing, recreation, voluntary work, and other activities, to ensure the safety of each detainee. The Auditor will request intake lists from various days to select random detainee to review the detainee files for the intake risk assessment and the individualized determinations for housing, recreation, voluntary work, and other activities for standard compliance.

Corrective Action Taken (a): The Auditor requested that the documentation of training on how to utilize the risk assessment form when considering a detainee for a voluntary work program or for recreational purposes. The facility provided an email stating AGS Processing staff receives formal training on the ERO Language Service Resource Flyer. The facility did not provide documentation that processing staff actually received the training as required by the Auditor. The facility submitted 10 detainee files, as instructed by the Auditor, that contained the Voluntary Work Program, Voluntary Worker Screening Form. The Auditor reviewed all 10 files and determined that the forms utilized do not consider the detainee's risk for victimization or whether the detainee has a history of being a sexual predator when determining recreation and other activities, and voluntary work. In addition, the form did not take into consideration whether the detainee is LGBTQ, including transgender. The Auditor further reviewed the 10 detainee files and determined that the facility utilizes the In Processing Vulnerability Questionnaire, in conjunction with the RCA, in determining custody level only; however, specific individual housing assignments are not determined utilizing the risk assessment information as required by the standard. The facility is not compliant with standard 115.42 (a).

(b): Policy KRO/20.3.3 states "in making assessments and housing decisions for transgender or intersex detainees, the facility will consider the detainee's gender and self-identification, and assessment of the effects of placement on the detainee's health and safety." The policy further indicates "transgender and intersex detainees shall be reassessed at least twice a year." During the Remote Interview phase of the audit, two specialized interviews with transgender detainees were conducted by the Second Auditor. Neither detainee recalled being reassessed and only one reported being seen by medical. The Lead Auditor reviewed the files of the two transgender detainees and was unable to confirm that the detainees were referred to medical or mental health upon intake. One detainee's file was accompanied by the detainee's medical and mental health files. The detainee file labeled the detainee as transgender on January 7, 2020; however, the detainee arrived at KNSPC on December 1, 2019. In the medical and mental health files provided, neither indicated that the detainee was transgender upon intake. There were no additional records provided that could confirm the detainee was referred to medical or mental health upon the detainee disclosing transgender status on January 7, 2020. The documentation provided also could not confirm that transgender and intersex detainees were reassessed at least twice a year. Interviews with intake and medical staff indicated that a medical and mental health professional will be consulted on a case-by-case basis, to determine whether the placement would present management or security concerns. There were no transgender or intersex detainees to interview during the on-site portion of the Audit. A review of an additional transgender detainee's detention file, provided on-site, confirmed the detainee did not receive a reassessment as mandated by the standard.

Does Not Meet (b): Following the review of two transgender detainee A-files, and one transgender detainee's detention file, in conjunction with interviews with intake and medical staff who indicated that a medical and mental health professional will be consulted on a case-by-case basis as opposed to consulting with medical or mental health staff on all transgender housing assessments, the Lead Auditor confirmed that not all transgender, or intersex, detainees are assessed upon intake to determine if the facility's placement of a transgender or intersex detainee is consistent with the safety and security of the facility as required by the subpart (b) of the standard. The Lead Auditor further confirmed following the review of a transgender detainee's detention file that the facility does not re-assess each transgender or intersex detainee at least twice a year to review and threats to safety experienced by the detainee. The facility must consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety, consistent with the safety and security considerations of the facility, which includes a consult by medical or mental health staff as soon as practicable on the assessment. The facility must reassess each transgender or intersex detainee at least twice each year to review any threats to safety experienced by the detainee. The facility must provide two intake risk screenings of a transgender or intersex detainee with facility housing placement determination that considers the detainee's self-identification and the health and safety of the detainee.

Corrective Action Taken (b): The facility submitted one transgender detainee file. The Auditor reviewed the file and determined that although the detainee was labelled transgender at the risk screening, and submitted a request for general population, the available information does not confirm that the facility considered the detainee's self-identification or assessed the effects of placement on the detainee's health and safety when determining individual housing. In addition, there is no confirmation that the facility consulted medical or mental health prior to determining housing assignment. As the transgender detainee had not been at the facility for six months, the Auditor could not confirm that the facility is now reassessing transgender or intersex detainees a least twice a year to review any threats to safety experienced by the detainee. The facility in not compliant with 115.42 (b).

§115. 51 - Detainee reporting
Outcome: Does not Meet Standard
Notes:

(c): Policy KRO/20.2.11 outlines procedures for staff to "accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports." Interviews with the PSA Compliance Manager, security staff, including line staff and first-line supervisors, stated if they received a report of sexual misconduct, they would document the allegation on a facility incident report and forward it on through the appropriate channels for investigation. In review of 16 completed sexual abuse investigations, nine allegations were reported to facility staff by the alleged victim, one was reported by a third party, and six were grievances submitted by the alleged victim. The Lead Auditor determined all but two cases were completed in accordance with the standard. In the one case, staff failed to report an incident of sexual abuse reported by the alleged victim. As a result, the facility determined the staff did not follow policy and was subsequently terminated from employment. In the other case, the staff person failed to report the incident of sexual abuse and submitted the required incident report four days following the detainee reporting the sexual abuse incident and after the allegation was reported to the facility through the detainee's attorney.

Does Not Meet (c): An in depth review of 11 allegations of sexual abuse, where the detainee reported to staff, the Lead Auditor confirmed that in two of the cases, the facility staff failed to promptly report, and document, an incident of sexual abuse as required by subpart (c) of the standard. The facility must conduct refresher training with staff on the reporting and proper document of any verbal reports of sexual abuse. The facility must provide a copy of the training materials and documentation that staff completed the training for compliance review

Corrective Action Taken (c): The Auditor requested that the facility provide a listing of staff hired since the audit so that a random sampling of 10 training records can be chosen by the Auditor and reviewed for compliance with the training required. The facility provided the auditor with a list entitled, "AGS Employee Hired on/after 1/28/2021 to present, Airport, Armed Officer, Food Service;" however, they only provided two training check lists entitled PREA reporting requirements. The two forms are insufficient to determine compliance given the number of staff employed at KNSPC. The facility did not submit any investigative files to confirm that the allegations were reported promptly as required by the standard. The facility is not in compliance with standard 115.51 (c).

§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): Policy KRO/20.6.2 Grievance System details the formal grievance process for detainees to utilize involving allegations of an immediate threat to their health, safety, or welfare, and related to sexual abuse. "Grievances may be brought to a designated grievance officer (GO) or directly to the OIC or their designee. Detainees are permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. A detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives with filing a grievance relating to sexual misconduct. Facility staff are required to bring all medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility does not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse." Policy further states that "the detainee shall be provided with a written or oral response within five days of receipt of the grievance and the ICE FOD shall review the grievance appeal and issue a decision within five days of receipt of the appeal. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE FOD at the end of the grievance process." Interviews with the Grievance Coordinator and facility line staff, during the contingency portion of the Audit, could not corroborate the above-mentioned policy. The Grievance Coordinator was new to the position and could not accurately answer the interview questions. The majority of facility line staff advised they do not handle grievances and that detainees place grievances in the "Grievance Box." When pressed, some facility line staff indicated they would accept a grievance if handed to them while others indicated they would not handle a grievance under any circumstance. During the on-site portion of the Audit, the Audit team, through interviews with facility staff and the facility's PSA Compliance Manager, confirmed that the procedure in place was being affected by the current pandemic. The Grievance Coordinator was working remotely and not completing daily rounds to gather potential emergency grievances in the housing units. In addition, the "grievance box" located in the cafeteria was no longer accessible to the detainees, as the areas was closed due to the pandemic. According to a facility memo submitted with the PAQ and an interview with the Grievance Coordinator, the facility has not received any grievances in the past 12 months regarding allegations of sexual abuse. Therefore, no grievances were submitted to the Lead Auditor to review. However, six sexual abuse allegations submitted by the facility recorded that the allegations were reported through the grievance system. During the on-site portion of the Audit, the Lead Auditor was able to review a sexual abuse grievance submitted by a detainee to the grievance officer utilizing the "electronic pad" issued to each detainee. According to the grievance submitted, the detainee reported an incident of sexual abuse on 12/22/2020. The Grievance Coordinator responded to the detainee the same day, advising the detainee that the grievance was forwarded to ICE and AGS Supervisors and PREA Coordinators for investigation. The Grievance Coordinator then labeled the grievance as "open." The grievance remained opened until 01/05/2021 when it was

determined unfounded and officially closed. Therefore, the facility did not issue a decision on the grievance within five days of receipt. On 1/7/2021, the detainee filed an appeal and was issued a decision on 01/26/2021, confirming compliance with this part of the standard. Interviews with detainees did confirm they are aware of the facility grievance process and that they can request assistance in filing a grievance if needed.

Does Not Meet (a)(b)(c)(d)(e)(f): The facility's procedure for filing an anonymous grievance is not being followed. The facility cafeteria, where the grievance box is located, was closed to detainee access and the Grievance Officer is working remotely. During the interviews with facility line staff, some staff indicated that they would not accept a detainee grievance under any circumstances. Additional interviews with facility staff and the facility PREA Compliance Manager further confirmed that at the time of the on-site audit, the facility had not adjusted the procedures to allow detainees a way to submit a grievance of an incident of sexual abuse since the Grievance Officer was working remotely and was not collecting grievances daily from the housing units. In review of the one available detainee grievance, it was 15 days from the opening of the grievance until the detainee was notified that the grievance was closed as unfounded. The facility agreed that the procedures needed to be updated to provide a process to collect grievance forms from the housing units daily during the pandemic; however, they did not provide the Audit team with a solution prior to the conclusion of the on-site portion of the audit. The facility must develop a process for detainees to submit sexual abuse grievances, including time sensitive sexual abuse grievances that involve an immediate threat to detainee health, safety, or welfare, to the Grievance Coordinator or other designee during disruptions in normal operating procedures, and the facility must issue a decision on all sexual abuse grievances within the standard timeframes. The facility must also submit written guidelines to ensure sexual abuse grievances, including time sensitive grievances are retrieved and submitted for review in a timely manner. The facility must provide the written protocols for retrieving grievances to ensure timely processing and a list of all sexual abuse grievances reported within a determined time frame; the Auditor will select random grievance files to review to determine standard compliance.

Corrective Action Taken (a)(b)(c)(d)(e)(f): The facility submitted a memorandum to the Lead Auditor that states, "As suggested by the Corrective Action Plan (CAP), KNSPC installed grievance boxes on all dormitory buildings. The grievance boxes are emptied daily by the collateral duty grievance officer and/ or his alternate." In addition, the facility submitted a photo of a newly installed grievance box. The facility is in compliance with standard 115.52 (a)(b)(c)(d)(e)(f).

§115. 61 - Staff reporting duties
Outcome: Does not Meet Standard
Notes:

(b): Policy KRO/20.2.11 "requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Employees are required to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible. Staff are required to promptly document any verbal reports as well." Interviews during the contingency portion of the audit with the PSA Compliance Manager, AFOD, and random facility staff, it was clearly articulated by staff the protocols in place as it relates to staff reporting duties, with the exception of how staff can report allegations of sexual misconduct outside of their normal supervisory chain of command, if needed. The policy states that "KNSPC shall have written policy and procedures for a SAAPI program that includes procedures for immediately reporting sexual abuse allegations, including a method by which staff can report outside the chain of command;" however, these procedures are not outlined further in KRO/20.2.11. The Second Auditor was able to confirm compliance through random interviews with facility staff, who were knowledgeable as to how to report an incident of sexual abuse outside the chain of command. A review of the 10 sexual abuse investigations, where the detainee reported the allegation to staff, confirmed that not all staff immediately reported the allegation as required by the standard. In one of the allegations, the facility staff member failed to report an allegation and in response, the facility terminated the employee for failing to adhere to PREA policies, by not reporting the allegation, and then falsifying records in an effort to cover up his failure to follow KNSPC's reporting policy. The facility provided a copy of the termination letter to document the termination. During the review of the second sexual abuse investigation, a facility staff member failed to immediately report the incident and then reported the incident four days later. An investigation was started two days after the incident as a result of an email from the detainee's attorney's reporting the incident. According to the results of the investigation, there was no follow-up discipline for the facility staff member involved.

Does Not Meet (b): In review of 10 allegations of sexual abuse, where the detainee, or a third party, reported a sexual abuse allegation to staff, the Lead Auditor confirmed that in two of the cases, the facility staff failed to promptly report, and document, the allegation as required by subpart (b) of the standard. All facility staff are required to report immediately and according to agency and facility policy any knowledge, suspicion, or information regarding an incident of sexual abuse. The

facility must provide and document refresher training to all facility staff on reporting requirements. The facility must provide a copy of the training materials and documentation of training completed by staff for compliance review.

Corrective Action Taken (b): The Lead Auditor required that the facility submit a copy of the training materials for reporting requirements, a complete list of contract employees, and documentation that the facility staff received the training. The facility provided the auditor with a partial list of contract staff and their titles. The list was titled "contract staff that completed refresher training on the reporting requirement." The submitted list from the facility was not signed or dated and did not include all staff. The facility did not provide sign in sheets to verify who completed the training and/or when to confirm compliance with subpart (b) the standard. The facility is not in compliance with standard 115.61 (b).

§115. 67 - Agency protection against retaliation
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): Policy KRO/20.2.11 outlines the facility's procedures for protection against retaliation. The policy states "staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least 90 days following a report of sexual abuse, the facility will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation." The policy states that "KNSPC will continue such monitoring beyond 90 days if the initial monitoring indicates a need to do so." During the interview with the Lead Auditor, the OIC indicated she was unaware of how the monitoring of staff and/or detainees was conducted at KNSPC. Documents provided with the PAQ documented that monitoring of detainees was conducted for the first 30 days, but monitoring thereafter could not be confirmed, nor could the documents confirm if the facility monitored detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff as required by the standard. However, during an interview with the facility's PSA Compliance Manager, while on-site, the Lead Auditor determined that the detainee is monitored for at least 90 days following a report of sexual abuse and will continue to monitor beyond 90 days, if the initial monitoring indicates a continued need. The facility's PSA Compliance Manager further confirmed that the monitoring takes into consideration detainee disciplinary reports, housing or program changes, and negative performance reviews. He does not contact the detainee, at any time during the monitoring period for a face-to-face meeting, to discuss whether the detainee needs emotional support services for fear of retaliation for reporting sexual abuse or for cooperating with investigations. In addition, the PSA Compliance Manager further confirmed during the interview, that the facility does not have a procedure to monitor retaliation against staff, nor are there support services available for staff who fear retaliation for reporting sexual abuse or for cooperating with investigations.

Does Not Meet (a)(b)(c): During the on-site portion of the Audit, the Lead Auditor confirmed through review of documentation for retaliation monitoring, that there is a process in place to monitor detainees for retaliation, as required by the standard; however, there is no face-to-face interaction to determine a need for emotional services due to a fear of retaliation for reporting sexual abuse or for cooperating with investigations or documentation that demonstrated the facility monitors detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff as required by the standard. Also, detainee retaliation monitoring could not be confirmed for the 90-day period. In addition, the PSA Compliance Manager further confirmed the facility does not have a procedure to monitor retaliation against staff and there are no support services available for staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. The facility must develop a process to monitor staff for retaliation and act promptly to remedy any such retaliation as required by policy and standard. The facility must provide examples of retaliation monitoring for detainees and staff for at least 90 days following a report of sexual abuse and any actions that may have been taken to remedy any such retaliation. The documentation needs to demonstrate face-to face monitoring and detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff are monitored for possible retaliation for standard compliance.

Corrective Action Taken (a)(b)(c): The facility reflected in their CAP response they would update their policy to read all PREA Investigators will conduct face-to-face interviews when monitoring detainees that report sexual abuse and train their PREA investigators on the amended policy. The Auditor requested a copy of the updated policy , documentation that all PREA Investigators were trained on the new policy and examples of detainee monitoring to further confirm the new policy in practice. The facility did not supply a new policy, or any training documentation needed to confirm compliance with the standard. The facility provided a "Log of Sexual Allegations – Miami Field Office" that indicated three out of 10 detainees were not monitored for 90 days as required. In addition, the facility submitted one sexual abuse investigation file that did not confirm facility monitoring of the victim. The facility is not in compliance with standard 115.67 (a)(b)(c).

§115. 77 - Corrective action for contractors and volunteers
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): Policy KRO/20.2.11 states "any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees. The policy further states that incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies, unless the activity was clearly not criminal and that the facility shall also report such incidents to the ICE FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." In addition, the policy states "the facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards." An interview with the OIC confirmed volunteers and contractors are subject to termination and/or prohibited contact from detainees for violations of the department's sexual abuse policies. Further, the facility will take appropriate measures when considering whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within the standard. A review of the facility's sexual abuse allegation investigations indicated that there were no incidents of sexual abuse that involved volunteers or contractors.

A review of 16 sexual abuse investigation files confirmed that, during the audit period, the facility has had two documented incidents in which contract staff have failed to follow facility sexual abuse policies, by failing to immediately report an allegation of sexual abuse. In one of the allegations, the contract staff member failed to report an allegation and in response, the facility terminated the individual for failing to adhere to PREA policies, by not reporting the allegation and then falsifying records, in an effort to cover up his failure to follow KNSPC's reporting policy. The facility provided a copy of the termination letter to document the termination. During the review of the second sexual abuse investigation, a contract facility staff member failed to immediately report the incident and then reported the incident four days later. An investigation was started two days after the incident as a result of an email from the detainee's attorney's reporting the incident. According to the results of the investigation, there was no follow-up discipline for the contract facility staff involved. During the audit period, the facility had seven allegations that involved staff-on-detainee, four of which were sexual abuse incidents claiming inappropriate pat-searches involving contract facility. All contract staff were immediately reassigned to a post removed from detainee contact until the outcome of the investigation. As part of the on-site portion of the Audit, the Lead Auditor reviewed a seventh allegation of sexual misconduct by contract staff. As with the other six investigations reviewed, the contract staff person was immediately reassigned to a post removed from detainee contact, until the outcome of the investigation period. Based on the findings of "unsubstantiated," there were no files to review in which a termination was warranted.

Does Not Meet (b): In review of 16 allegations of sexual abuse investigations, the Lead Auditor confirmed that, in two of the cases, the contract facility staff failed to promptly report and document an incident of sexual abuse as required by subpart (b) of the standard. In one of the incidents reviewed, the facility terminated the contract facility staff member; however, in the second and most recent incident, the facility took no action against the contract facility staff member for failing to report, and immediately document the incident when reported to him by the detainee. Facility contract staff are subject to disciplinary or adverse action up to and including removal from their position for violating agency or facility sexual abuse policies. The facility must provide examples of staff disciplinary or termination of staff who has engaged in sexual abuse or for violating the agency of facility's sexual abuse policies, if applicable during the CAP period. The facility must also provide and document refresher training to the appropriate staff, on the disciplinary or adverse actions for staff for substantiated allegations of sexual abuse, or for violating agency or facility sexual abuse policies for compliance review. This training documentation must be provided to the Auditor for compliance review.

Corrective Action Taken (b): The facility was required to provide examples of staff disciplinary or termination of staff who has engaged in sexual abuse or for violating the agency of facility's sexual abuse policies, if applicable during the CAP period. The facility provided a "Log of Sexual Allegations – Miami Field Office" to confirm that no employee/contractor violated agency or facility sexual abuse policies and/or engaged in sexual abuse during the CAP period. In addition, the facility provided a memorandum to the Auditor documenting there was no instances during the CAP period. However, the facility did not provide documentation that refresher training was provided to appropriate staff on the disciplinary or adverse actions for staff for substantiated allegations of sexual abuse, or for violating agency or facility sexual abuse policies for compliance review. Therefore, the facility in not in compliance with standard 115.77 subsection (b).

§115. 81 - Medical and mental health assessments; history of sexual abuse
Outcome: Does not Meet Standard
Notes:

(a)(b)(c) Standard 115.81 states that "if the assessment pursuant to 115.41 indicates the detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. In addition, the detainee shall receive a health evaluation no later than two working days from the date of the assessment and when a referral for mental health is indicated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." Interviews with medical and mental health care staff confirmed, if a referral for medical follow-up is initiated for a detainee who reported a sexual abuse history, the detainee will receive a health care evaluation no later than 2 working days from the initial assessment and if a referral for mental health follow-up is initiated, the detainee will receive a mental health evaluation no later than 72 hours. Interviews with intake processing staff and medical staff assigned to intake, confirm that detainees, who are known detainee on detainee abusers on intake, are not referred to mental health for possible treatment, nor are they offered medical treatment if appropriate. In an interview with mental health staff, the Lead Auditor confirmed that they are not provided the names of known abusers and therefore, they are not seen. During the on-site portion of the Audit, medical staff who perform intake screening noted that they had not had a detainee report a history of sexual abuse in over five years. Mental Health staff reported during an on-site interview that they would not share, with need-to-know staff, whether a detainee reported a sexual abuse history to mental health staff.

Does Not Meet (a)(b)(c): Interviews with medical and mental health staff confirmed that detainees, who perpetrated sexual abuse, are not referred for medical or mental health evaluation, as required by the standard. Per medical staff interviewed, detainees who perpetrate sexual abuse will only be seen by medical in instances where physical injury is apparent. Mental health staff confirmed that they are not provided the names of known abusers and therefore, they are not seen by mental health. The facility must develop a process to ensure that the intake and medical staff, completing the risk assessments, refer a detainee that has experienced prior sexual victimization or perpetrated sexual abuse to a qualified medical or mental health practitioner, for medical and/or mental health follow-up as appropriate. The intake and medical staff who complete risk assessments must be trained on the referral process and training documented. The facility must provide risk assessments and follow-up medical and/or mental health notes for 10 detainees that have experienced prior sexual victimization or perpetrated sexual abuse and documented staff training for compliance review, if applicable during the CAP period.

Corrective Action Taken (a)(b)(c): The Auditor requested the facility develop a process to ensure that the intake and medical staff completing risk assessments refer a detainee that has experienced prior sexual victimization or perpetrated sexual abuse be referred to a qualified medical or mental health practitioner and that the processing and medical staff be trained on the new procedure. The facility did not submit a new process or documented training on the process. In addition, the Auditor requested that the facility provide risk assessments and follow-up for 10 detainees that have experienced sexual victimization or perpetrated sexual abuse. The facility did not provide 10 detainee files as requested. The facility provided a list of Medical/Mental Health staff as requested by the Auditor. Based on the list, the Auditor requested to review the training files of 10 Medical/Mental staff; however the training documentation provided did not reflect training on a new policy or process. The facility is not in compliance with standard 115.81 (a)(b)(c).

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

(g): KRO/20.2.11 states "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." An interview with mental health staff confirmed an attempt would be made to conduct a mental health evaluation of a known detainee abuser within 60 calendar days or sooner of learning of such abuse history and offer treatment deemed appropriate, however, she further indicated that they are not given the names of known abusers; and therefore, they are not seen. The Lead Auditor's review of mental health records submitted by the facility of both detainee victims and their known abusers indicated that despite mental health staff knowledge of the abuser's identity as reported to them by the victim, there was no attempt to offer treatment. In addition, interviews with intake processing staff and medical staff assigned to do intake, confirm that detainees who are known detainee- on-detainee abusers on intake, are not referred to mental health for possible treatment.

Does Not Meet (g): Interviews with mental health staff, intake staff, and medical staff assigned to complete intake processing confirmed that known detainee-on-detainee abusers are not referred at intake to mental health staff for possible treatment upon intake. In addition, the Lead Auditor's review of mental health records, submitted by the facility of both detainee victims and their known abusers, indicated that despite mental health staff's knowledge of the abuser's identity as reported to them by the victim, there was no attempt to offer the abuser treatment. The facility must develop a process to ensure that intake and medical staff completing risk assessments, refer a known detainee-on-detainee abuser and facility

staff refer identified abusers of a substantiated allegation to mental health to offer treatment, where deemed appropriate by mental health practitioners. The intake and medical staff who complete risk assessments and other appropriate staff must be trained on the referral process of known detainee-on-detainee abusers and the completed staff training is documented. The facility must provide documentation of referrals and follow-up medical and/or mental health notes for five detainees that are known detainee on detainee abusers (if applicable during the CAP process) and documentation of staff training completed for compliance review**.**

Corrective Action Taken (g): The Auditor requested the facility develop a process to ensure that the intake, medical, and facility staff completing risk assessments, and/or are involved in investigating allegations of sexual abuse, refer a detainee that is an identified abuser of a substantiated case of sexual abuse to mental health to offer treatment. In addition, the Auditor requested that effected staff receive documented training on the new process. The facility did not provide a new policy/process, nor did it provide documentation of staff training. The Auditor further requested referrals and medical and mental health follow up on five detainees that are known detainee on detainee abusers. The facility provided one investigation that indicated that the known abuser was seen by mental health; however, not for PREA related incident. The facility is not in compliance with standard 115.83 (g).

§115. 87 - Data collection

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

Notes:

Policy KRO/20.2.11 states that "the facility shall maintain a secure area where all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be maintained in appropriate files in accordance with these detention policies, and retained in accordance with established schedules." The PSA Compliance Manager confirmed the facility maintains these documents locked in his office with access on a need-to-know basis only. However, a review of 22 detainee files (12 detention files and 10 A-files), by the Audit team, confirmed that the Investigative Findings and Responsive Actions Notifications are also filed in the detainee's detention file as directed on the notification form, which is accessible to all employees and therefore, available to more than those with a need-to know basis.

Does Not Meet: A review of 12 detention files confirmed that the Investigative Findings and Responsive Actions Notifications are inappropriately filed in the detainees' detention file making the form accessible to all employees, including facility staff and not maintained in a secure area. Per direction provided on the form, it is to be filed in the investigative file. The facility must develop a plan or directive to maintain all case records associated with allegations of sexual abuse in the appropriate files to ensure security of the information and develop a secure area to maintain all sexual abuse case records. This plan and the location of the secure case records must be shared with the Auditor for compliance review.

Corrective Action Taken: The facility provided a memo to all staff advising the staff to no longer place the outcome notice to the detainee in their detention file. The facility also submitted one investigation file that confirmed that the notice to detainee routing information was removed from the notification form. The facility is in compliance with standard 115.87 (a).

AUDITOR CERTIFICATION:

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

Sabina Kaplan January 19, 2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) January 20, 2022

Program Manager's Signature & Date