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

Homeland Security

AUDITOR INFORMATION			
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Miami		
Field Office Director:	Garrett Ripa		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	865 SW 78th Avenue Plantation, FL 33324		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Krome North Service Processing Center		
Physical address:	18201 Southwest 12Th Street Miami, Florida 33194		
Telephone number:	305.207.221		
Facility type:	Service Processing Center		
PREA Incorporation Date:	5/29/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer In Charge (OIC)
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	305.207.(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	305.207.(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS

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

During the audit, the Auditor found Krome North Service Processing Center (KNSPC) met 19 standards, had 0 standards that exceeded, had 1 standard that was non-applicable, and had 21 non-compliant standards. As a result of the facility being out of compliance with 21 standards, the facility entered into a 180-day corrective action period which began on September 13, 2023, and ended on March 11, 2024. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance. The Corrective Action Plan (CAP) period review was assigned to Sabina Kaplan, DOJ and DHS PREA Auditor, and Assistant Program Manager (APM), contracted through Creative Corrections, LLC, for those standards found to be deficient during the facility's July 11-13, 2023 PREA audit.

The facility submitted documentation, through the Agency, for the CAP on October 13, 2023, through March 11, 2024. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. In addition, the APM with the assistance of the External Reviews and Analysis Unit (ERAU) Team Lead (TL) (b) (6), (b) (7)(C) and the Agency Prevention of Sexual Assault Coordinator (PSAC), revisited the facility January 23, 2024, through January 24, 2024, to provide further guidance to allow the facility to come into compliance during the CAP period.

Before the start of the CAP on-site revisit, the APM, ERAU TL, the Agency PSAC met with Agency and facility staff. In attendance were:

(b) (6), (b) (7)(C) Agency PSAC, ICE Office of the Director
(b) (6), (b) (7)(C), TL, Inspection and Compliance Specialist (ICS), ICE ERAU
(b) (6), (b) (7)(C), Assistant Field Office Director (AFOD), ICE Enforcement and Removal Operations (ERO)
(b) (6), (b) (7)(C), Health Services Administrator (HSA), ICE Health Services Corp (IHSC)
(b) (6), (b) (7)(C), Assistant HSA, IHSC
(b) (6), (b) (7)(C), Quality Assurance Manager (QAM), AGS KNSPC
(b) (6), (b) (7)(C), Program Manager (PM), AGS KNSPC
(b) (6), (b) (7)(C), APM, AGS KNSPC
(b) (6), (b) (7)(C), Assistant Program Manager (APM), Akima Global Services (AGS) KNSPC
(b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (SDDO), ICE ERO
(b) (6), (b) (7)(C), ERO Compliance ICE
(b) (6), (b) (7)(C), ERO Compliance ICE
(b) (6), (b) (7)(C), Detention and Deportation Offices (DDO) ICE ERO
(b) (6), (b) (7)(C), DDO ICE ERO
(b) (6), (b) (7)(C), DDO ICE ERO
(b) (6), (b) (7)(C), DDO ICE ERO
(b) (6), (b) (7)(C), APM Creative Corrections, LLC

Brief introductions were made, and the APM discussed the purpose of the on-site re-visit which was to provide further guidance to the facility to come into compliance with all standards found to be deficient during the July 11-13, 2023 audit. A tour of the areas found deficient during the July 11-13, 2023 was completed by the APM, ERAU TL, Agency PSAC, and key facility staff. Areas re-visited included the Krome Behavioral Health Unit (KBHU) and Intake Processing. In addition, to the tour the APM reviewed detainee files, KBHU post orders, medical files, and sexual abuse allegation investigation files associated with the deficient standards.

The APM, ERAU TL, and Agency PSAC met with key staff upon the conclusion of the re-visit. In attendance were:

(b) (6), (b) (7)(C), Agency PSAC, ICE Office of the Director
(b) (6), (b) (7)(C), TL, ICS ICE ERAU
(b) (6), (b) (7)(C), AFOD, ICE ERO
(b) (6), (b) (7)(C), PM, AGS KNSPC
(b) (6), (b) (7)(C), QAM, AGS KNSPC
(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), Assistant HSA, IHSC
(b) (6), (b) (7)(C), ERO Compliance ICE
(b) (6), (b) (7)(C), ERO Compliance ICE
(b) (6), (b) (7)(C), DDO ICE ERO
(b) (6), (b) (7)(C), DDO ICE ERO
(b) (6), (b) (7)(C), DDO ICE ERO
(b) (6), (b) (7)(C), APM Creative Corrections, LLC

The APM explained to staff attending 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 APM thanked the staff for the hospitality and cooperation provided throughout the on-site re-visit.

The APM reviewed the final documentation submitted on March 15, 2024. In a review of the submitted documentation, both on the ICE SharePoint, and during the facility re-visit, to demonstrate compliance with the deficient standards, the APM and Auditor determined compliance with 18 of the standards and found that 3 of the standards continue to be non-compliant based on the submitted documentation or lack thereof.

Number of Standards Initially Not Met: 21

- §115.13 - Detainee supervision and monitoring
- §115.15 - Limits to cross-gender viewing and searches
- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
- §115.17 - Hiring and promotion decisions
- §115.18 - Upgrades to facilities and technologies
- §115.21 - Evidence protocols and forensic medical examinations
- §115.32 - Other Training
- §115.33 - Detainee Education
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.43 - Protective Custody
- §115.51 - Detainee Reporting
- §115.53 - Detainee access to outside confidential support services
- §115.61 - Staff and Agency Reporting Duties
- §115.65 - Coordinated Response
- §115.67 - Agency protection against retaliation

- §115.73 - Reporting to detainees
- §115.81 - Medical and mental health screening; history of sexual abuse
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review

Number of Standards Exceeded: 0

Number of Standards Met: 18

- §115.13 - Detainee supervision and monitoring
- §115.15 - Limits to cross-gender viewing and searches
- §115.17 - Hiring and promotion decisions
- §115.18 - Upgrades to facilities and technologies
- §115.21 - Evidence protocols and forensic medical examinations
- §115.32 - Other Training
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.43 - Protective Custody
- §115.51 - Detainee Reporting
- §115.61 - Staff and Agency Reporting Duties
- §115.65 - Coordinated Response
- §115.67 - Agency protection against retaliation
- §115.73 - Reporting to detainees
- §115.81 - Medical and mental health screening; history of sexual abuse
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review

Number of Standards Not Met: 3

- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
- §115.33 - Detainee Education
- §115.53 - Detainee access to outside confidential support services

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

Notes:

(a)(b)(c)(d): KNSPC policy 2.10, Searches of Detainees, states, "Staff shall conduct frequent unannounced security inspections to identify and deter sexual abuse of detainees. Such inspections shall be implemented for night as well as day shifts. Staff is prohibited from alerting others that the security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility." A review of the KNSPC PAQ indicates the facility employs 382 AGS security staff, with duty hours from 0600-1400, 1400-2200 and 2200-0600, consisting of 254 males and 128 females who may have reoccurring contact with detainees. In addition, to security staff, the remaining staff consists of administration, medical, and food service. Medical and mental health services are provided to detainees though ICE IHSC, PHS, and STG International. Maintenance services are provided by OFAM International Management and Consulting Services and Commissary staff are employed by Japlop Enterprises, Inc. Volunteer religious services are provided by Jesuit Refugee Services, USA. The PAQ further indicates there are (b) (7)(E) , with PTZ capabilities, located throughout the facility. Auditor observations confirmed the facility has sufficient supervision of detainees to protect them from sexual abuse. During the on-site audit, the Auditor reviewed the facility comprehensive supervision guidelines and confirmed they were reviewed in February 2023. The guidelines outline the responsibilities of detainee supervision including the requirement to make frequent unannounced security inspections of the unit that are not regular and routine. The APM and Auditor reviewed housing unit logbooks in the Krome Behavior Health Unit (KBHU) and Buildings (b) (7)(E) on two consecutive days in July 2023 and confirmed entries had been made that confirmed unannounced security inspections were conducted on seven out of 10 entries making the facility in substantial compliance with subsection (d) of the standard. An interview with a facility Captain indicated staff are prohibited from alerting others when unannounced rounds are occurring. Although requested, the facility did not provide the Auditor with documentation to confirm when determining staffing levels and the need for video monitoring, the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody. In addition, an interview with the OIC confirmed staffing levels are determined by the physical layout of the facility, length of stay, and the composition of the detainee population.

Corrective Action:

(c): The facility is not in compliance with subsection (c) of the standard. Although requested, the facility did not provide the Auditor with documentation to confirm when determining staffing levels and the need for video monitoring, the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time

detainees spend in Agency custody. In addition, an interview with the OIC confirmed staffing levels are determined by the physical layout of the facility, length of stay, and the composition of the detainee population. To become compliant, the facility must submit documentation that confirms the facility took into consideration when determining adequate staffing levels and the need for video monitoring, generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody.

Corrective Action Taken:

(c): The facility provided the Auditor a memorandum, from the PSA Compliance Manager to the AFOD, which indicates the facility complies with the standard by reviewing reports submitted to management such as the Krome Annual SAAPI Report and the AGS Staffing Plan Evaluation to determine adequate staffing levels and the need for video monitoring. In addition, the facility provided the Auditor the AGS Staffing Plan and AGS Annual Reports for the years 2022 and 2023. The Auditor reviewed the submitted documentation and confirmed the facility takes into consideration when determining adequate staffing levels generally accepted detention and correctional practices, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody; however, a review of the documentation could not confirm the facility takes into consideration any judicial findings of inadequacy or with the exception of the prevalence of substantiated and unsubstantiated incidents of sexual abuse and the findings and recommendations of sexual abuse incident review reports, the facility took into consideration the elements of subsection (c) when determining the need for video monitoring. The facility submitted a memorandum which states, "During FY22 and FY23 there were no "judicial findings of inadequacy" involving the Krome SPC Facility. If judicial findings of inadequacy had been reported Krome SPC would have taken into consideration the finding when determining adequate staffing levels and the need for video monitoring." In addition, the Facility submitted a memorandum to the file which states, "My office is aware that in order to be in compliance with PREA standards, specifically 6 CFR 115.18 (b) "Upgrades to facilities and technologies", the facility, when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, shall take into consideration how such technology may enhance its ability to protect detainees from sexual abuse. Moving forward my office will ensure the ICE ERO, IHSC, AGS and specifically the PSA Compliance Manager is included and consulted prior to making any physical changes to the facility, to ensure any changes proposed will take into consideration the ability to protect detainees from sexual abuse" which the Auditor accepts for substantial compliance with standard 115.18. The APM reviewed the updated 2023 Annual Sexual Abuse and Assault Report while on-site and confirmed the updated 2023 Annual Sexual Abuse and Assault Report considered when determining the need for video monitoring the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody. In addition, the facility submitted the updated 2023 Annual Sexual Abuse and Assault Report reviewed by the APM while on-site. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsection (c) of the standard.

§115.15 - Limits to cross-gender viewing and searches

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

Notes:

(b)(c)(d): KNSPC policy 2.10 states, "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. Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances. All cross-gender pat-down searches shall be documented. When an officer of the opposite gender conducts a strip search which is observed by a staff member of the same gender as the detainee, staff shall document the reasons for the opposite-gender search in any logs used to record searches and in the detainee's detention file." The Auditor reviewed a memorandum to the file which states, "In the last 12 months the Krome Service Processing Center did not have any cross-gender pat down searches." Interviews with four random AGS security line staff confirmed cross-gender pat-down searches are not conducted at KNSPC. Interviews with four random AGS security line staff further confirmed should a cross-gender pat down search be required, due to exigent circumstances, they were aware all cross-gender pat-searches are required to be documented. During interviews with 20 random detainees, it was confirmed each detainee had a pat-down search conducted at the facility by an officer of the same gender. In addition, during the on-site audit, the Auditors observed five pat-down searches and confirmed each search had been performed by an officer of the same gender as the detainee. The facility does not house female detainees.

(e)(f): KNSPC policy 2.10 states, "Cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Facility staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches shall be documented." Interviews with four random AGS security line staff confirmed all strip searches, cross gender strip searches, and visual body cavity searches must be documented. Each staff member indicated that they have not conducted or witnessed a cross-gender strip search or a visual body cavity search at the facility. Interviews with 20 random detainees confirmed 19 have not been subject to a strip searched, or had a visual body cavity search, while housed at the facility. However, one transgender detainee reported she had been stripped search. She reported she requested the search be completed by a female officer and the request was granted. The Auditor reviewed the transgender detainee file and confirmed the strip search had been documented and was not conducted for the purpose of determining her genital characteristics.

(g): KNSPC policy 4.5, Personal Hygiene, states, "Staff of the opposite gender are prohibited from viewing detainees showering, performing bodily functions, and changing clothes. Detainees shall be provided with a reasonably private environment in accordance with safety and security needs. Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." Interviews with two female AGS security line staff indicated detainees are permitted to shower, change clothing, and perform bodily functions without being viewed by the opposite gender and that staff are required to announce their presence when entering housing units occupied by detainees of the opposite gender. In addition, during the on-site audit, the Auditors observed female staff announcing their presence when entering the unit. Interviews with 20 detainees, indicated that they are aware when female staff enter the unit. Some reported they can see the female staff when they enter the unit and others reported they will announce "female on floor". The Auditor viewed all camera views from the (b) (7)(E) and confirmed (b) (7)(E) or (b) (7)(E) areas could not be seen, as a black box was digitally added to prevent viewing of these areas, by the person monitoring the cameras; however, a view of the camera angles from the (b) (7)(E) confirmed detainees housed in the dorm areas could be seen by cross gender staff when changing their clothing. An interview with the PSA Compliance Manager indicated detainees are notified of cross gender viewing by (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) in the facility handbook; however, a review of the facility handbook confirms detainees are not advised that they could be seen in a state of undress when changing their clothes in areas other than the bathrooms or showers. In addition to the camera angles, the Auditor observed opposite gender viewing issues while detainees performed bodily functions in the IHSC medical area cells (b) (7)(E) and the negative pressure cell

[redacted]. During the on-site audit the Auditor also observed in the KBHU, A and B side, mirrors were installed within the shower area to eliminate a significant blind spot; however, the mirrors allowed anyone passing by the area to view detainees in a state of undress while showering. In addition, the [redacted] showers allowed cross gender viewing of transgenders and intersex detainees when using the shower as the curtain length was inadequate.

(h): The facility is not designated as a Family Residential Unit; and therefore, subsection (h) is not applicable.

(i)(j): KNSPC policy 2.10 states, "Krome SPC shall not search or physically examine a detainee for the sole purpose of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. All strip searches shall be documented." KNSPC Policy 2.10 further states, "Security staff shall be trained in proper procedures for conducting pat searches, including cross-gender pat searches and searches of transgender and intersex detainees." Interviews with four random AGS security line staff indicated they are aware transgender and intersex detainees could not be searched or physically examined for the sole purpose of determining the detainee's gender. If there was a need to know the detainee would be taken to medical for determination. Interviews with four random AGS security line staff further indicated, they have received training in proper procedures for conducting pat-down searches, including cross-gender searches and searches of transgender/intersex detainees in a professional and respectful manner. Interviews with two transgender detainees, indicated they have had a pat-down search at the facility and stated they were allowed to choose the gender of the officer conducting the search. In addition, both transgenders interviewed stated the pat-down searches had been done professionally and respectfully. One transgender detainee reported she had been stripped searched. She further reported she requested the search be completed by a female officer and the request was granted. The Auditor reviewed the transgender detainee file and confirmed the strip search had been documented and not conducted for the purpose of determining her genital characteristics. The Auditor reviewed the AGS Detainee Searches and the ICE Cross-Gender, Transgender and Intersex Searches training curriculums and confirmed the training includes proper procedures for conducting pat-down searches, including pat-down searches conducted by the opposite gender, searches of transgender/intersex detainees, in a professional and respectful manner, consistent with security needs and the facility policy, including consideration of officer safety. The Auditors reviewed 31 staff training files that confirmed staff have completed the required training.

Corrective Action:

(g): The facility is not in compliance with subsection (g) of the standard. During the on-site audit, the Auditor viewed all camera views from the [redacted] and confirmed cross gender viewing issues when detainees in [redacted] were changing their clothing. An interview with the PSA Compliance Manager indicated detainees are notified of cross gender viewing by [redacted] in the detainee handbook; however, a review of the facility handbook confirms detainees are not advised that they could be seen in the state of undress if they are changing their clothes in areas other than the bathroom or shower areas. In addition, during the on-site audit the Auditor observed opposite gender viewing issues while detainees performed bodily functions in the IHSC medical area cells [redacted] and the negative pressure cell [redacted]. During the on-site audit the Auditor also observed In the KBHU, [redacted] were installed within [redacted] to eliminate a significant blind spot; however, the mirrors allow anyone passing by the area to view detainees in a state of undress while [redacted] In addition, the [redacted] showers allowed cross gender viewing of transgenders and intersex detainees when using [redacted] as the curtain length was inadequate. To become compliant, the facility must submit documentation that confirms all detainees have the ability 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.

Corrective Action Taken:

(g): The facility submitted KRO 4.5 Personal Hygiene which states, "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." The facility provided an email that includes revised bullets for the facility orientation program to include, "Non-citizens are advised there may be potential cross gender viewing by (b) (7)(E) during routine cell checks for safety." The facility provided a copy of the updated facility Detainee Handbook which confirms the information regarding cross-gender viewing has been added. The facility submitted a memorandum which states, "In accordance with PREA provision §115.15 (g), "staff of the opposite gender are required to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing. To be in compliance with this standard it is required that all detainees have the ability 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. The process is effective immediately, is to be adhered to, and is as follows." The facility submitted a revised Processing Officer 1 Post Order which states, "If a detainee identifies as transgender/intersex do not house in (b) (7)(E) In addition, the facility submitted an updated In-Processing Special Vulnerability Questionnaire which includes, "If any identity selected other than man, do not house in (b) (7)(E) ." The APM toured the KBHU during the on-site re-visit and confirmed with the exception of when viewing is incidental to routine cell checks or exigent circumstances, the shower areas do not allow for anyone passing by the area to view detainees in a state of undress while showering. During the on-site re-visit, the APM reviewed an updated post order KBHU Desk Officer (A-side)/KBHU Front Lobby Desk and confirmed the updated post order requires staff to allow only one detainee at a time to utilize the shower area. The facility submitted the updated post order KBHU Desk Officer (A-side), KBH Front Lobby Desk, reviewed on-site which confirmed the post orders require staff to allow only one detainee at a time to utilize the shower area. The facility submitted an email to all security supervisors, and one read receipt, to confirm all security supervisors were trained on the updated post orders. The facility submitted emails to facility Captains and KBHU staff which confirm staff assigned to the KBHU have received training on the updated post orders. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsection (g) of the standard.

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

Outcome: Does not Meet Standard

Notes:

(a)(b): KNPSC policy 2.11 states, "The facility shall take appropriate steps to ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Such steps shall include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, (a) Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. (b) Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication with detainees with disabilities, including detainees who have intellectual disabilities, limited reading skills, or who are blind or have low vision. The facility shall take steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. In matters relating to allegations of sexual abuse, each facility shall employ

effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. Each facility shall provide detainees with disabilities and detainees with Limited English Proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. Where practicable, provisions for written translation of materials related to sexual abuse or assault shall be made for other significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." Interviews with two AGS Intake staff indicated, during the intake process detainees are given the ICE National Detainee Handbook, and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet in their preferred language. AGS Intake staff further indicated the detainee will receive a copy of the facility detainee handbook (Local Supplement), available in English, Spanish, Mandarin, Haitian Creole, and Arabic, and will watch a PREA Video available in English, Spanish and Haitian Creole. In addition, interviews with AGS Intake staff and four random AGS security line staff indicated, if a detainee is LEP, there are staff interpreters who can interpret for those who speak Spanish. AGS Intake staff and four random AGS security line staff further indicated, if the detainee speaks a language other than Spanish, English, or Haitian Creole staff would utilize language line services provided through Lionbridge Interpretation Services. However, staff could not articulate how PREA information would be provided to detainees who are deaf or hard of hearing or who were blind or had low vision in a format they would understand. During the on-site audit the APM observed a teletypewriter (TTY) machine; however, none of the AGS Intake staff could articulate how to use the machine. In an interview with one AGS Intake Officer, it was indicated he would use the TTY machine to provide information detainees who were blind or had limited sight. In interviews with AGS Intake staff, it was further indicated if a detainee had limited reading skills, or had intellectual, psychiatric, or other disabilities staff would seek assistance from medical staff. In addition, in interviews with AGS Intake staff it was indicated detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of PREA information; however, the APM observed during the intake processing of a detainee whose preferred language was Russian, AGS Intake staff required the detainee to sign the form, prior to receiving any written PREA information or watching the PREA portion of the video. In an interview with the processing AGS Intake Officer it was confirmed the detainee would receive the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet in his preferred language, Russian; however, he would only get the facility handbook in English. The Auditor reviewed the detainee's file and although the detainee insisted his preferred language was Russian the AGS Intake Officer noted the detainee's preferred language as English. In an interview with the AGS Intake Officer, it was confirmed he could not articulate how the information in the facility handbook would be provided to the detainee using the language line or how the detainee would receive the information available through the video. During the on-site audit the Auditor observed a facility PREA information sheet and the facility handbook in English, Spanish, Mandarin, Haitian Creole and Arabic and the ICE National Detainee Handbook in English and Spanish; however, AGS Intake staff were able to articulate their ability to print the ICE National Detainee Handbook in any of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. During the initial on-site tour, the Auditor did not observe the DHS-prescribed SAA Information pamphlet in the processing area; however, the facility located the pamphlets and the APM confirmed through observation the facility had begun distributing the pamphlet during the intake process. The Auditor observed the facility PREA information sheet on the detainee tablets; however, the sheet was only provided in English. An interview with a detainee whose preferred language was Arabic, indicated he could not read or write English or Spanish; however, he was provided a copy of the ICE National

Detainee Handbook and the local facility handbook in English only. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was Arabic. The Auditors reviewed 44 detainee files and based on information provided in the files, and on-site observations, the Auditor could not confirm that detainees who were LEP, or who were deaf or hard of hearing, were blind or had low vision, or had speech, intellectual, or psychiatric difficulties had received the PREA information in a format they could understand.

(c): KNPSC policy 2.11 states, "Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. Interviews with four random AGS security line staff indicated they would not use a detainee to interpret for another detainee under any circumstances.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. In interviews with AGS Intake staff and four random AGS security line staff it was indicated, if the detainee speaks a language other than Spanish, English, or Haitian Creole staff would utilize language line services provided through Lionbridge Interpretation Services. However, staff could not articulate how PREA information would be provided to detainees who are deaf or hard of hearing or who were blind or had low vision in a format they would understand. During the on-site audit the APM observed a teletypewriter (TTY) machine; however, none of the AGS Intake staff could articulate how to use the machine. AGS Intake staff indicated detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of the PREA information; however, AGS Intake staff further indicated detainees are asked to sign the form, prior to receiving the handbooks or watching the PREA portion of video. During the on-site audit, the Auditor observed the facility handbook (Local Supplement) available in English, Spanish, Mandarin, Haitian Creole, and Arabic and the facility orientation video in English, Spanish and Creole. PREA information was also observed on the detainee tablets: however, it was only provided in English. An interview with a detainee whose preferred language was Arabic indicated, he could not read or write English or Spanish; however, he was provided a copy of the ICE Detainee Handbook and the local facility handbook in English only. During the intake process of a detainee whose preferred language was Russian the APM observed AGS Intake staff required the detainee to sign the form, prior to receiving any written PREA information or watching the PREA portion of the video. In addition, a review of the detainee's file confirmed the AGS Intake Officer noted the detainee's preferred language as English. In an interview with the AGS Intake Officer, it was confirmed he could not articulate how the information in the facility handbook would be provided to the detainee using the language line or how the detainee would receive the information available through the video. The Auditors reviewed 44 detainee files and based on information provided in the files, and on-site observations, the Auditor could not confirm that detainees who were LEP, or who were deaf or hard of hearing, were blind or had low vision, or had speech, intellectual, or psychiatric difficulties had received the PREA information in a format they could understand. To become compliant, the facility must provide documentation that confirms all detainees have an equal opportunity to participate in or benefit from all aspects of the Agency's efforts to prevent, detect, and respond to sexual abuse including those who are LEP, have limited sight or are blind, or are hard of hearing or deaf. Once implemented the facility must submit documentation that all AGS Intake staff have been trained on the new procedures. In addition, if applicable, the facility must provide the Auditor with 10 detainee files who do not speak English, Spanish, Mandarin, Haitian Creole, and Arabic and are processed on different days to confirm the detainees are receiving PREA information in a manner all detainees can understand. In addition, if applicable the facility must submit three detainee files that include detainees who have limited sight or are blind or are hard of hearing or deaf to confirm they received PREA information in a

manner they can understand. All detainee files must include detainees received during the corrective action plan (CAP) period.

(c): The facility is not in compliance with subsection (c) of the standard. Although stated KNSPC policy 2.11 interviews with four random AGS security line staff confirmed they would not use a detainee to interpret for another detainee under any circumstances. To become compliant, the facility must submit documentation that all AGS security line staff, supervisors, and Investigators were trained on the standard's requirement in matters relating to sexual abuse, the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. In addition, if applicable, the facility must submit five sexual abuse allegation investigation files that include LEP detainee victims that were closed during the CAP period.

Corrective Action Taken:

(a)(b): The facility submitted an email sent to all supervisors, which states, "Any ICE detainee encountered in intake that does not speak English, Spanish and/or French must be provided the same PREA-SAAPI information as everyone else. To accomplish this, staff will contact the language hotline and have the ICE "Sexual Abuse and Assault Awareness" pamphlet verbally interpreted into the language understood by the detainee. Additionally, the PREA-SAAPI information included in the facility handbook and ICE National Detainee Handbook, that is not available anywhere else, will also be verbally interpreted into the language understood by the detainee. Staff will document this interaction by noting the interpreter unique identifier number and detainee signature with the paperwork. Supervisors, please respond to this email to confirm that your intake staff have reviewed and understood it and will proceed accordingly." The facility submitted a response email which confirmed intake staff have reviewed and understood the email. The facility submitted an Orientation Video transcript in Russian and English. During the on-site CAP revisit the APM toured the intake area and confirmed the facility has translated the orientation video into numerous languages encountered by ICE; however, through observation, and an interview with a processing officer, the APM confirmed detainees who have limited reading skills are not getting the information in a manner detainees could understand. In addition, during the on-site CAP revisit the APM observed the facility distributed the ICE National Detainee Handbook during the intake process; however, in an interview with a processing officer it was confirmed the DHS-prescribed SAA Information pamphlet was included in the distributed ICE National Detainee Handbook; and therefore, the APM confirmed the facility only distributed the DHS-prescribed SAA Information pamphlet in English, Spanish, Haitian Creole, Arabic, French, Hindi, Portuguese, and Punjabi. The facility submitted a copy of an updated "LEP form" which gives the detainee the option to waive "continuing in English" as opposed to his preferred language and to waive the information gained from the orientation video in his preferred language; however, the standard requires the facility provide both the Agency and facility PREA information in a manner all LEP detainees can understand; and therefore, the implemented updated "LEP form" did not meet the standard. During a Q & A on February 29, 2024, via telephone, between the facility, APM, ERAU, SAPPI Unit staff, and the Agency PSAC the APM advised the facility the LEP form did not meet the standard and provided ways to become compliant during the CAP period; however, the implemented form was not updated prior to the CAP period's end date. The facility submitted a copy of the LEP form completed by a detainee of Polish descent who indicated his preferred language was English. A review of the signed LEP form confirmed the detainee indicated his preferred language was English. The facility submitted an updated Orientation Acknowledgement; however, although the detainee indicated his preferred language was English on the LEP form the Orientation Acknowledgement was provided to the detainee in Polish. In addition, the facility submitted a copy of the information regarding a local rape crisis center given to the detainee; however, although the detainee indicated his preferred language was English on the LEP form the facility submitted the information given to the detainee in Polish. Therefore, based on the submitted documentation the APM and Auditor could not confirm the facility has satisfactorily implemented a

practice which ensures all detainees have an equal opportunity to participate in or benefit from all aspects of the Agency's efforts to prevent, detect, and respond to sexual abuse. The facility submitted an updated Special Circumstances Detainee Orientation Acknowledgement Form for a detainee with limited reading skills which states, "AGS officers have read in my language to me." The facility uploaded copies of the orientation video translated in Arabic, Hindi, Mandarin, Portuguese, and Russian viewed by the APM during the on-site CAP revisit to the 115.16 CAP folder. The facility submitted a memo to Auditor which indicates there have been no detainees received at Krome following the on-site revisit who have limited sight or are blind or hard of hearing or deaf. Upon review of all submitted documentation, or lack thereof, the APM and Auditor continue to find the facility does not meet subsections (a) and (b) of the standard.

(c): The facility submitted a PREA Refresher Training which includes the standard's requirement in matters relating to sexual abuse, the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. The refresher training includes a statement "I acknowledge that I have reviewed and understand the PREA Refresher training material provided by the facility to include the specific provisions below." PREA standard 115.16 (c) is included. In addition, the facility submitted eight signed training acknowledgements which confirm staff have received the required training. During the on-site CAP revisit the APM reviewed a closed sexual abuse investigation file which confirms Investigators in matters relating to sexual abuse, provided in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. The facility submitted the closed sexual abuse investigation file reviewed on-site to the 115.16 CAP folder. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsection (c) of the standard.

§115.17 - Hiring and promotion decisions

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

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." AGS policy 201, Employment Offers, states, "The Company shall not hire or promote anyone who may have contact with detainees, and shall not enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or

refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. The Company when considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct described in (6 CFR, 115.17) in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The Company shall also impose upon employees a continuing affirmative duty to disclose any such misconduct. The Company, consistent with law, shall make its best efforts to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. Before hiring new staff, who may have contact with detainees, the Company shall conduct a background investigation to determine whether the candidate for hire is suitable for employment with the Company, including a criminal background records check. Upon request by the agency, the Company shall submit for the agency's approval written documentation showing the detailed elements of the Company background check for each staff member and the Company's conclusions. The Company shall require an updated background investigation every five years for employees who may have contact with detainees. The Company shall conduct an updated background investigation every five years for those facility staff who may have contact with detainees and who work in immigration-only detention facilities. The Company shall also perform a background investigation before enlisting the services of any contractor who may have contact with detainees. Upon request by the Company, the Company shall submit for the agency's approval written documentation showing the detailed elements of the Company's background check for each contractor and the Company's conclusions. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate. In the event the Agency contracts with a company for the confinement of detainees, the requirements of this section otherwise applicable to the agency also apply to the Company and its staff." An interview with the HMR indicated that before hiring a potential employee they must complete the Electronic Questionnaire for Investigation Processing (e-QIP) and must provide fingerprints. The HRM further indicated background checks are completed by the ICE PSU and ICE will determine suitability for hiring. In addition, the HRM indicated prior to being hired all staff and staff/contractors are required to fill out a Declaration for Federal Employment which states, "All your answers must be truthful and complete. A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you or for firing you after you begin work." The HRM further indicated, all staff and contractors are required to complete the DHS 6 Code of Federal Regulations Part 115 which asks potential staff/contractors all questions required by subsection (a) of the standard. In addition, the HRM indicated, prior to being hired all staff and contractor staff are required to sign a form which states, "I understand that a knowing and willful false response may result in a negative finding regarding my fitness as a contract employee supporting ICE. Furthermore, should my answers change at any time I understand I am responsible for immediately reporting the information to my Program Manager." The Auditor submitted names for 14 ICE staff, 14 AGS staff, 1 STG International staff, and 8 IHSC staff, to the ICE PSD PREA Audit Unit (PSU). Documentation was provided confirming all submitted names had completed a background check and all required forms prior to being hired and background rechecks were conducted every five years as required. However, although requested, no documentation was submitted to the Auditor to confirm volunteers or "other" contractors who may have contact with detainees were asked about the behaviors required by subsection (a) of the standard prior to utilizing their services. An interview with the HRM indicated that the facility does not inquire about previous sexual misconduct prior to staff promotions. The HRM further indicated information would be provided on substantiated allegations of sexual abuse involving a former employee if a request was received. An interview with the AFOD confirmed he had not been asked about previous sexual misconduct in a written application or during an interview prior to his promotion to his current position.

Corrective Action:

(a)(b): The Agency and facility are not in compliance with subsections (a) and (b) of the standard. Although requested, the facility did not provide documentation to confirm volunteers or "other" contractors who may have contact with detainees are asked about the behaviors required by subsection (a) of the standard prior to utilizing

their services. An interview with the HRM confirmed the facility does not inquire about previous misconduct prior to staff promotions. In addition, an interview with the AFOD confirmed he was recently promoted to the AFOD position; however, he had not been asked about previous sexual misconduct in a written application or during an interview prior receiving the promotion. To become compliant, the facility shall establish a procedure to ensure that all volunteers or "other" contractors who have contact with detainees are asked about the prohibited behaviors per subsection (a) of the standard prior to utilizing their services. In addition, the facility must submit five volunteer and five "other" contractor records to confirm they are asked about the prohibited behaviors per subsection (a) of the standard prior to utilizing their services. In addition, if applicable, the Agency and facility must submit employee records of any employee promoted during the CAP period.

Corrective Action Taken:

(a)(b): The facility submitted five religious volunteer files which confirmed 6 Code of Federal Regulations Part 115 was completed prior to utilizing the services of the volunteers. During the on-site CAP re-visit the APM submitted 8 "other contractor" names to PSO and confirmed seven "other contractors'" completed the 6 Code of Federal Regulations Part 115 prior to the facility utilizing their services and one "other contractor" was not found. The facility submitted the PSO Background Clearance form required by the APM to the 115.17 CAP folder. There were no Agency or facility employees promoted during the CAP period. Upon review of all submitted documentation the APM and Auditor now find the facility in substantial compliance with subsections (a) and (b) of the standard.

§115.18 - Upgrades to facilities and technologies

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

Notes:

(a)(b): KNSPC Policy 2.11 states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility shall consider the effect of the design, acquisition, expansion, or modification upon its ability to protect detainees from sexual abuse. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, the facility shall consider how such technology may enhance its ability to protect detainees from sexual abuse." The Auditor reviewed a memorandum to the file which states, "The Krome SPC facility has recently completed modifications to the bathroom facilities in the housing units. The modification consisted of adding privacy walls to the toilet areas to provide detainees with additional privacy." The Auditor reviewed an email request to make the bathrooms PREA compliant which confirmed the facility considered the effect of the design to enhance their ability to protect detainees from sexual abuse. During an interview with the facility PSA Compliance Manager, it was indicated the facility had updated the video technology in the last year. The PSA Compliance Manager further indicated he was not included or consulted regarding the placement of the cameras. In addition, the documentation provided to the Auditor could not confirm the facility took into consideration how the technology will protect the detainees from sexual abuse. During the on-site audit, the Auditor observed the facility is currently undergoing construction of a new detainee cafeteria; however, documentation provided did not confirm the facility considered how the design of the cafeteria, may enhance the facility's ability to protect detainees from sexual abuse.

Recommendation: The Auditor recommends that the facility take into consideration how the design of the detainee cafeteria may enhance the facility's ability to protect detainees from sexual abuse.

Corrective Action:

(b): During an interview with the facility PSA Compliance Manager, it was indicated the facility had updated the video technology in the last year. The PSA Compliance Manager further indicated he was not included or consulted regarding the placement of the cameras. In addition, the documentation provided to the Auditor could

not confirm the facility took into consideration how the technology will protect the detainees from sexual abuse. To become compliant the facility must submit documentation that confirms when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, the facility took into consideration how such technology may enhance its ability to protect detainees from sexual abuse.

Corrective Action Taken:

(b): The facility submitted an email from the Building Manager to the SDDO which indicates "moving forward when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, ICE ERO, IHSC, and the PSA Compliance Manager will be consulted to ensure that any changes proposed takes into consideration the ability to best protect detainees from sexual abuse." The facility submitted a memorandum to the file which states, "My office is aware that in order to be in compliance with PREA standards, specifically 6 CFR 115.18 (b) "Upgrades to facilities and technologies", the facility, when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, shall take into consideration how such technology may enhance its ability to protect detainees from sexual abuse. Moving forward my office will ensure the ICE ERO, IHSC, AGS and specifically the PSA Compliance Manager is included and consulted prior to making any physical changes to the facility, to ensure any changes proposed will take into consideration the ability to protect detainees from sexual abuse." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

§115.21 - Evidence protocols and forensic medical examinations

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

Notes:

(a)(b)(c)(d)(e): The Agency's policy 11062.2, outlines the Agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." KNSPC policy 2.11 states, "The facility is responsible for investigating allegations of sexual abuse involving detainees, it shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable. The facility shall consider how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victims' needs. The facility shall establish procedures to make available, to the full extent possible, outside victim services following incidents of sexual abuse. Additionally, the facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the facility shall provide these services by making available a qualified staff member from a community-based organization, or a qualified agency staff member. A qualified agency staff member or a qualified community-based staff member means an individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals. Where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility shall arrange for an alleged victim detainee to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other

qualified health care personnel. As requested by a victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. To the extent that the agency is not responsible for investigating allegations of sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of PREA (CFR 115.21) To the extent that the agency is not responsible for investigating allegations of sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of PREA (CFR 115.21. Interviews with two facility AGS Captains, four random AGS security line staff, the MCD, a facility RN, and a Mental Health provider, employed by STG International, indicated they were knowledgeable of the facility's evidence protocol and the steps to be taken if there was a sexual assault of a detainee. An interview with a facility Investigator indicated the facility would conduct administrative investigations and if the allegation was criminal in nature, the facility would notify the Miami Dade Police Department (MDPD) to conduct a criminal investigation into the allegations. The facility PAQ indicated the facility did not have any allegations that had been investigated by an outside agency; however, during the review of 10 sexual abuse allegation investigation files confirmed the Hollywood Police Department (HPD) had been notified and investigated one allegation. Although requested by the Auditor, the facility did not provide documentation to confirm that a request had been made of the Miami Dade Police Department, or the Hollywood Police Department to follow the requirements of paragraphs (a)-(d) of the §115.21. An interview with the facility MCD indicated that SAFE/SANE exams are performed at the Jackson Memorial Hospital through Roxcy Bolton Rape Treatment Center (RBRTC). The facility MCD further indicated the rape treatment center would provide a victim advocate, at the request of the detainee, to provide emotional support, crisis intervention, information, and any needed referrals, during the SANE/SAFE exam and investigatory interviews. The Auditor reviewed a memorandum to the file, which states, "ICE Health Service Corps is in the processing of securing a Memorandum of Understanding (MOU) agreement with the Jackson Hospital and Roxcy Bolton Rape Treatment Center to provide services to sexually assault victims. The MOU is pending final review and approval." The Auditor attempted to contact a representative of the SANE/SAFE unit at the Jackson Memorial Hospital; however, the attempts were unsuccessful. In an interview with a RBRTC advocate it was confirmed RNRTC advocates provide crisis intervention, counseling and emotional support during SANE/SAFE exams and investigatory interviews. Interviews with the AFOD and the facility PSA Compliance Manager confirmed the protocol was developed in coordination with DHS.

Corrective Action:

(e): The facility is not in compliance with subsection (e) of the standard. The facility PAQ indicated the facility did not have any allegations that had been investigated by an outside agency; however, during the review of 10 investigations it was confirmed the HPD had been notified and investigated one allegation. An interview with a facility Investigator indicated the facility would conduct administrative investigations and if the allegation was criminal in nature the facility would notify the MDPD to conduct a criminal investigation into the allegations. Although requested by the Auditor, the facility did not provide documentation to confirm that a request had been made of the MSPD or the HPD to follow the requirements of paragraphs (a)-(d) of the standard. To become compliant, the facility must provide the Auditor with documentation that confirms the facility has requested the MDPD and HPD follow the requirements of paragraphs (a)-(d) of the standard when investigating an allegation of sexual abuse at KNSPC.

Corrective Action Taken:

(e): The facility submitted a memorandum addressed to HPD which includes a request for the HPD to follow the requirements of paragraphs (a)-(d) of the standard. The facility submitted an email to the MDPD which confirms the facility requested the MDPD to follow the requirements of paragraphs (a)-(d) of the standard when investigating an allegation of sexual abuse at Krome. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsection (e) of the standard.

§115.32 - Other Training

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

Notes:

(a)(b)(c): KNSPC policy 2.11 states, "Krome SPC shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed how to report such incidents. In this paragraph "other contractor" means a person who provides services on a non-recurring basis to the facility pursuant to a contractual agreement with the agency or facility. Krome SPC must maintain written documentation verifying employee, volunteer, and contractor training." The Auditor reviewed the training curriculum and confirmed all elements required by the standard are included. An interview with the facility Chaplin indicated all persons who provide religious services are volunteers and receive PREA training prior to providing services and refresher training is required annually. During the on-site audit, the facility provided the Auditor with Volunteer Training Sign-in sheets, indicating all volunteers have received PREA training for 2022; however, although requested by the APM the facility did not provide documentation to confirm maintenance staff employed by OFAM International Management Services or Commissary staff employed by Japlop Industries, both considered to be "other" contractors, received the required training.

Corrective Action:

(a)(c): The facility is not in compliance with subsections (a) and (c) of the standard. Although requested during the on-site audit the facility did not provide the Auditor with documentation that confirms maintenance staff employed by OFAM International Management Services or Commissary staff employed by Japlop Industries, both considered to be "other" contractors, received training on the Agency's and facility's zero-tolerance policy regarding sexual abuse or informed on how to report such incidents. To become compliant, the facility must provide the Auditor documentation to confirm "other" contractors have been trained on the Agency's and facility's zero-tolerance policy regarding sexual abuse and informed on how to report such incidents.

Corrective Action Taken:

(a)(c): The facility provided the Auditor with PREA Training Certifications for 4 Commissary staff. The certifications confirm Commissary staff have been trained on the Agency's zero-tolerance policy and how to report an incident; however, the certificates do not confirm "other" contract staff have received training on the facility's zero-tolerance policy. During the on-site audit the APM accepted the facility's explanation which confirmed as an Agency run facility the facility zero-tolerance policy is also the Agency zero-tolerance policy. In addition, the APM confirmed contract staff not employed by the Agency receive Agency developed training; and therefore, receive the Agency's zero-tolerance policy. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsections (a) and (c) of the standard.

§115.33 - Detainee Education

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): KNSPC policy 2.11 states, "Following the intake process, the Krome SPC shall provide instruction to detainees on the Krome SPC's Sexual Abuse and Assault Prevention and Intervention Program and ensure that such instruction includes (at a minimum): Krome SPC's zero-tolerance policy for all forms of sexual abuse or assault; Prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual activity; Explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the

Detention and Reporting Information Line (DRIL), the DHS/OIG and the ICE/OPR investigation processes; Information about self-protection and indicators of sexual abuse; Prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainees immigration proceedings; and Right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." During the on-site audit, the Auditors observed the DHS-prescribed sexual abuse and assault notice, which contained the name of the facility PSA Compliance Manager, and the phone number for RBRTC posted on housing unit bulletin boards and other various locations throughout the facility. The Auditor observed an outdated poster in the holding trailer; however, upon notification the facility immediately replaced the notice with the updated version. Interviews with two Intake staff indicated PREA orientation occurs during the intake process when detainees are given the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet in their preferred language. Intake staff further indicated the detainee will receive a copy of the facility detainee handbook (Local Supplement), and a PREA handout, both available in English, Spanish, Mandarin, Haitian Creole and Arabic, and will watch a PREA Video available in English, Spanish, and Haitian Creole. In addition, interviews with Intake staff and four random AGS security line staff, indicated if a detainee is LEP, there are staff interpreters who can interpret for those who speak Spanish and should a detainee speak a language other than Spanish, English, or Haitian Creole Intake staff would utilize the language line services provided through Lionbridge Interpretation Services. However, staff could not articulate how PREA information would be provided to a detainee who was deaf or hard of hearing or was blind or had low vision in a format they would understand. During the on-site audit the Auditor observed a TTY machine; however, none of the intake staff could articulate how to use the machine. In an interview with one Intake Officer, it was indicated staff would use the machine to provide detainees who are blind or have limited site the PREA information. In interviews with Intake staff, it was further indicated if a detainee had limited reading skills, is intellectually, psychiatric or has other disabilities, staff would seek assistance from medical staff. In addition, interviews with Intake staff indicated detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of the PREA information; however, the APM observed detainees being processed during the on-site audit and confirmed detainees are asked to sign the form prior to receiving any written PREA information or watching the PREA portion of the video. In an interview with the Classification Officer, it was confirmed the handbooks are provided to the detainee during the classification interview. During the on-site audit the Auditor observed the facility handbook in English, Spanish, Mandarin, Haitian Creole and Arabic and the ICE National Detainee Handbook in English and Spanish. However, Intake staff were able to articulate their ability to print the ICE National Detainee Handbook in any of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. In addition, the Auditor did not observe the DHS-prescribed SAA Information pamphlet in the processing area; however, the facility did locate the pamphlets and the APM confirmed, through observation, the facility had begun distributing them, during the intake process. A review of the ICE National Detainee Handbook and the facility local handbook confirmed all elements required by the standard are included in the handbooks. Interviews with 20 detainees indicated, 10 detainees had received the handbooks and 10 detainees either did not receive the handbooks or could not remember if they had received them. A review of 20 detainee detention files indicated all 20 detainees had signed the Detainee Summary indicating receipt of the documentation; however, observation during the intake process confirmed the detainee is required to sign the form prior to receiving the PREA information; and therefore, the Auditor could not confirm the information was provided to the detainee. In addition, a review of 20 detainee files indicated that in 11 of the files, the detainees completed the Detainee Summary three days, or more, after the date of intake. An interview with an Arabic detainee, indicated he could not read or write English or Spanish; however, he was provided a copy of the ICE National Detainee Handbook and the facility handbook (Local Supplement) in English only. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was Arabic. In addition, the APM observed the intake process of a detainee whose preferred language was Russian. After several attempts to read the information to the detainee Intake staff attempted to utilize the Lionsbridge language line; however, the interpreter could not hear them and eventually hung up. In an interview

with the Intake Officer, it was confirmed the detainee would receive the ICE National Detainee National Handbook in Russian; however, would only receive the facility handbook (Local Supplement) and the PREA information sheet in English as they were not available in Russian. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was English despite the detainee's insistence that his preferred language was Russian.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. Interviews with Intake staff confirmed detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of the PREA information; however, during the observation of detainees being processed the APM observed the detainees are required to sign the form prior to receiving the PREA information or watching the PREA portion of the video; and therefore, the Auditor could not confirm the detainee is receiving orientation as required by the standard. Services. In interviews with Intake staff, it was confirmed staff could not articulate how PREA information would be provided to a detainee who was deaf or hard of hearing or was blind or had low vision. A review of 20 detainee detention files indicated all 20 detainees had signed the Detainee Summary indicating receipt of the documentation; however, observation during the intake process confirmed the detainee is required to sign the form prior to receiving the PREA information. In addition, a review of 20 detainee files indicated that in 11 of the files, the detainees completed the Detainee Summary three days or more after the date of intake. The APM observed the intake process of a detainee whose preferred language was Russian. After several attempts to read the PREA information to the detainee staff attempted to utilize the language line; however, the interpreter could not hear them and eventually hung up. In response, staff indicated the detainee would receive the ICE National Detainee Handbook in his preferred language; however, he would receive both the facility handbook (Local Supplement) and PREA information sheet in English as the handbook was not available in Russian. To become compliant, the facility must provide documentation that all Intake and Classification staff are retrained on the facility orientation process. The training must include, during intake, a detainee shall not sign the Detainee Summary Form until he has received the PREA Information, including the PREA portion of the video, and completed orientation in a manner the detainee can understand. In addition, the facility must train all Intake staff on facility procedures for orientation of detainees who have limited hearing or are deaf or are blind or have low vision. The facility must provide the Auditor with 10 detainee files that include detainees who don't speak English, Spanish, Mandarin, Haitian Creole, or Arabic to confirm compliance with the standard's orientation requirements. If applicable, the facility must submit to the Auditor any detainee files that include detainees who have limited hearing or are deaf or are blind or have low vision. All detainee files must be from intake screenings that occurred during the CAP period.

Corrective Action Taken:

(a)(b): The facility submitted an email sent to all supervisors, which states, "Any ICE detainee encountered in intake that does not speak English, Spanish and/or French must be provided the same PREA-SAAPI information as everyone else. To accomplish this, staff will contact the language hotline and have the ICE "Sexual Abuse and Assault Awareness" pamphlet verbally interpreted into the language understood by the detainee. Additionally, the PREA-SAAPI information included in the facility handbook and ICE National Detainee Handbook, that is not available anywhere else, will also be verbally interpreted into the language understood by the detainee. Staff will document this interaction by noting the interpreter unique identifier number and detainee signature with the paperwork. Supervisors, please respond to this email to confirm that your intake staff have reviewed and understood it and will proceed accordingly." The facility submitted a response email which confirmed intake staff have reviewed and understood the email. The facility submitted an Orientation Video transcript in Russian and English. During the on-site CAP revisit the APM toured the intake area and confirmed the facility has translated the orientation video into numerous languages encountered by ICE; however, through observation, and an interview with a processing officer, the APM confirmed detainees who have limited reading skills are not getting the information in a manner detainees could understand. In addition, during the on-site CAP revisit the

APM observed the facility distributed the ICE National Detainee Handbook during the intake process; however, in an interview with a processing officer it was confirmed the DHS-prescribed SAA Information pamphlet was included in the distributed ICE National Detainee Handbook; and therefore, the Auditor confirmed the facility only distributed the DHS-prescribed SAA Information pamphlet in English, Spanish, Haitian Creole, Arabic, French, Hindi, Portuguese, and Punjabi. The facility submitted a copy of an updated "LEP form" which gives the detainee the option to waive "continuing in English" as opposed to his preferred language and to waive the information gained from the orientation video in his preferred language; however, the standard requires the facility provide both the Agency and facility PREA information in a manner all LEP detainees can understand; and therefore, the implemented updated "LEP form" did not meet the standard. During a Q &A on February 29, 2024, via telephone, between the facility, APM, ERAU, SAPPI Unit staff, and the Agency PSAC the APM advised the facility the LEP form did not meet the standard and provided ways to become compliant during the CAP period; however, the implemented form was not updated prior to the CAP period's end date. The facility submitted a copy of an updated LEP form completed by a detainee of Polish descent who indicated his preferred language was English. A review of the signed LEP form confirmed the detainee indicated his preferred language was English. The facility submitted an updated Orientation Acknowledgement; however, although the detainee indicated his preferred language was English on the LEP form the Orientation Acknowledgement was provided to the detainee in Polish. In addition, the facility submitted a copy of the information regarding a local rape crisis center given to the detainee; however, although the detainee indicated his preferred language was English on the LEP form the facility submitted the information given to the detainee in Polish. Therefore, based on the submitted documentation the Auditor could not confirm the facility has satisfactorily implemented a practice which ensures all detainees have an equal opportunity to participate in or benefit from all aspects of the Agency's efforts to prevent, detect, and respond to sexual abuse. The facility submitted an updated Special Circumstances Detainee Orientation Acknowledgement Form for a detainee with limited reading skills which states, "AGS officers have read in my language to me." The facility uploaded copies of the orientation video translated in Arabic, Hindi, Mandarin, Portuguese, and Russian viewed by the APM during the on-site CAP revisit to the 115.33 CAP folder. The facility submitted a memo to Auditor which indicates there have been no detainees received at Krome following the on-site revisit who have limited sight or are blind or hard of hearing or deaf. Upon review of all submitted documentation, or lack thereof, the APM and Auditor continue to find the facility does not meet subsections (a) and (b) of the standard.

§115.35 - Specialized training: Medical and mental health care

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

Notes:

(a)(b)(c): IHSC Directive 03-01states, IHSC has a zero-tolerance policy for sexual or physical assault, abuse, and sexual harassment. All IHSC staff receive training on the Sexual Abuse and Assault Prevention and Intervention (SAAPI) directive, PREA standards, and response protocol during initial orientation and annually thereafter throughout their employment with IHSC Training includes: 6-11-2 a Definition and examples of prohibited and illegal sexual behavior, recognizing situations where sexual abuse may occur. 6-11.2. b Detection and treatment of physically or sexually abused and assaulted detainee victims in ICE custody. 6-11.2. c Appropriate interventions when an incident occurs. 6-11.2. d Description of how to respond effectively and professionally to detainee victims of sexual abuse and assault, recognizing physical, behavioral, and emotional signs of sexual abuse. 6-11.2. e Discussion of how to communicate effectively and professionally to bisexual, transgender, intersex (LGBTI), or gender nonconforming detainee victims. 6-11.2. f Actions that will assist detainee victims to safeguard physical evidence of sexual abuse and assault. 6-11.2. g Steps for reporting allegations or suspicions of sexual abuse and assault. IHSC staff will not suffer retaliation for reporting abuse or assaults. 6-11.2. h Information for security staff on how to conduct "cross gender" pat down searches and searches of transgender and intersex detainees in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. 6-11.2. i How to identify and protect physical evidence with detainee victims,

including lesbians and gays, and how to identify and protect physical evidence, victims, including lesbians and gays, and how to protect physical evidence." KNSPC policy 2.11 states, "Facility medical staff shall be trained in procedures for examining and treating detainee victims of sexual abuse in facilities where medical staff may be assigned these activities. This training shall be subject to the review and approval of the Field Officer Director or other designated ICE official." However, the standard requires the facility have a policy that includes detecting signs of sexual abuse, responding professionally to victims of sexual abuse, and proper reporting allegations of suspicions of sexual abuse. The Auditor reviewed the IHSC Training curriculum and confirmed all elements required by the standard are included in the training material. The Auditor was provided training sign-in sheets, which indicated IHSC staff have received the specialized training. In addition, the Auditor was provided documentation to confirm all IHSC staff have completed general PREA training required by §115.31. Interviews with the facility MCD and a RN confirmed all medical and mental health staff, including PHS and STG International staff are required to attend the IHSC specialized training and the facility's general PREA training. The Auditor reviewed the training file of one STG International mental health provider and confirmed the required training was received. Interviews with the AFOD and the facility PSA Compliance Manager confirmed KNSPC policy 2.11 was referred and approved by the Agency.

Corrective Action:

(c): The Auditor reviewed IHSC Directive 03-01 and confirmed it includes all the required training elements of subsection (b) of the standard; however, subsection (c) of the standard requires the facility to have a policy that requires facility medical staff not employed by IHSC to receive training on detecting signs of sexual abuse, responding professionally to victims of sexual abuse, and proper reporting allegations of suspicions of sexual abuse. To become compliant the facility must submit documentation the confirms KNSPC policy 2.11 was updated to require facility medical staff employed by PHS and STG International to receive training on detecting signs of sexual abuse, responding professionally to victims of sexual abuse, and proper reporting allegations of suspicions of sexual abuse. Once updated the facility must submit documentation to confirm the updated KNSPC policy 2.11 was referred to the Agency for review and approval.

Corrective Action Taken:

(c): The facility submitted revised KNSPC policy 2.11 which states, "Staff not employed by DHS, or IHSC who serve as full-time/part-time medical or mental health employees must receive training on detecting signs of sexual abuse, responding professionally to victims of sexual abuse, and proper reporting allegations of suspicions of sexual abuse." In addition, a review of updated policy 2.11 confirms the policy was reviewed and approved by the AFOD on November 14, 2023. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsection (c) of the standard.

§115.41 - Assessment for risk of victimization and abusiveness

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

Notes:

(a)(b)(c)(d)(e): KNPSC policy 2.2, Custody Classification System, states, "The facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within twelve hours of admission to the facility. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: (1) Whether the detainee has a mental, physical, or developmental disability; (2) The age of the detainee; (3) The physical build and appearance of the detainee; (4) Whether the detainee has previously been incarcerated or detained; (5) The nature of the detainee's criminal history; (6) Whether the detainee has any convictions for sex offenses against adult or child; (7) Whether the detainee has self-identified as

gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the detainee has self-identified as having previously experienced sexual victimization; (9) The detainee's own concerns about his or her physical safety. The initial screening will take into account prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive." KNPSC policy 2.2 further states, "The detainee's risk of victimization or abusiveness will be reassessed between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." In interviews with Intake staff, it was indicated 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, how the detainee wishes to be identified (man or woman), whether the detainee has any previous convictions, whether the detainee has self-identified as having previously experienced sexual victimization, and the detainee's own concerns about his or her physical safety. A review of the RCA confirms it does not consider the detainee's physical build and appearance nor does it specifically ask the detainee if he identifies as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming or whether the detainee has any prior convictions for sexual abuse against an adult or child. In interviews with Intake staff, it was further indicated the facility utilizes a facility In-Processing Special Vulnerability Questionnaire to supplement the RCA which was updated recently. The Auditor reviewed the updated questionnaire and confirmed the questionnaire had recently been revised to specifically ask the detainee if he identifies as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; however, the revised questionnaire did not include the requirement to consider prior convictions for sex offenses against an adult or child. Interviews with the facility MCD and two RNs indicated during the medical intake, medical staff will review the In-Processing Special Vulnerability Questionnaire and will complete their own medical assessment which includes a PREA assessment. A review of the medical assessment utilized during intake confirms it captures any prior convictions for sexual abuse and the physical build and appearance of the detainee. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the interpreter could not hear them and eventually hung up: and therefore, the screening was not completed in Russian. In addition, the Auditor interviewed a detainee whose preferred language was Arabic, who indicated during the intake process he was spoken to in English only. The Auditor reviewed the detainee's file and confirmed he completed the In-Processing Special Vulnerability Questionnaire in English as the use of the language line was not documented. In interviews with the MCD, one RN, and a mental health provider it was indicated, a transgender detainee would be housed in the medical area, until a determination for housing is made, which would be within 24 hours and not the 12 hours required by the standard. The Auditors reviewed 44 detainee files and confirmed 31 detainee assessments had been completed utilizing the initial In-Processing Special Vulnerability Questionnaire prior to the questionnaire being revised for compliance. In addition, a review of 44 detainee files confirmed 8 detainees were placed in general population prior to the completion of their initial risk assessment which occurred three, or more, days after their initial intake. An interview with a facility Classification Officer indicated all detainees are reassessed at 60/90/120 day. The Classification Officer further indicated Classification staff will utilize the same vulnerability questionnaire that is used during the intake process to reassess the detainee. In addition, the Classification Officer indicated staff meets with the detainee, utilizing the same assessment done at intake. The Classification Officer further indicated in addition to the required reassessment one would be completed based on new information or following an incident of sexual abuse or victimization; however, the APM reviewed the submitted "Recommendation/Decision Log" which noted an incident of sexual abuse reported by a detainee; however, no documentation was submitted to confirm a reassessment of the detainee victim was completed. In addition, a review of 10 investigation files could not confirm a reassessment had been completed following an

incident of sexual abuse. The Auditors reviewed 44 detainee files and confirmed 13 detainees had a reassessment between 60 and 90 days, 8 had been reassessed prior to 60 days, 2 did not have documentation to indicate a reassessment had been completed, 1 had a reassessment in the file; however, it was blank, and 20 detainees had recently come into the facility and did not require a reassessment at the time of the on-site audit.

(f): KNPSC policy 2.11states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to paragraphs (c)(1), (c)(7), (c)(8) or (c)(9) of this section." During interviews with an Intake Officer, Classification Officer, and Disciplinary Officer, it was indicated detainees are not disciplined for refusing to answer questions or for not disclosing complete answers during the screening process.

(g): KNPSC policy 2.2 states "The facility shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates." An interview with the facility PSA Compliance Manager indicated all detainee files are kept in a locked cabinet.

Corrective Action:

(a)(b)(e): The facility is not in compliance with subsections (a), (b), and (e) of the standard. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the interpreter could not hear them and eventually hung up; and therefore, the screening was not completed in Russian. In addition, the Auditor interviewed a detainee whose preferred language was Arabic who indicated during the intake process he was spoken to in English only. The Auditor reviewed the detainee's file and confirmed he completed the In-Processing Special Vulnerability Questionnaire in English as the use of the language line was not documented. The Auditors reviewed 44 detainee files and confirmed 31 detainee assessments had been completed utilizing the initial In-Processing Special Vulnerability Questionnaire prior to it being revised for compliance. In addition, a review of 44 detainee files confirmed 8 detainees were placed in general population prior to the completion of their initial risk assessment which occurred three, or more, days after their initial intake. In an interview with the MCD, one RN, and a mental health provider it was indicated, a transgender detainee would be housed in the medical area, until a determination for housing was made which would be within 24 hours and not the 12 hours required by standard. An interview with the Classification Officer indicated a reassessment would be completed based on new information or following an incident of sexual abuse or victimization; however, the APM reviewed the submitted "Recommendation/Decision Log" which noted an incident of sexual abuse was reported by a detainee; however, no documentation was submitted to confirm a reassessment was completed. In addition, a review of 10 investigation files could not confirm a reassessment had been completed following an incident of sexual abuse. The Auditors reviewed 44 detainee files and confirmed out of 24 detainees who required a reassessment only 8 files confirmed the reassessment was completed within the required timeframe. To become compliant, the facility must implement a practice that ensures detainees who are LEP are assessed to identify those detainees who may be sexual abuse victims or aggressors in a manner that all detainees can understand. Once implemented the facility must submit documentation to confirm all Intake staff have been trained on the new procedure. In addition, the facility must submit documentation that all Intake and Classification staff have been retrained on the standards requirement to complete the initial assessment, and utilize the information gained from the initial risk assessment to identify those detainees likely to be sexual aggressors or sexual abuse victims, and to make housing determinations to mitigate any danger of sexual abuse. The facility must submit documentation that confirms all Intake and Classification staff, and facility Investigators are retrained on the standards requirement to reassess all detainees following an incident of sexual abuse. The facility must submit to the Auditor 10 detainee files that include detainees who do not speak English or Spanish to confirm the initial risk assessment was completed

within 12 hours and in a manner all detainees can understand. In addition, the facility must submit 10 detainee files that confirm a reassessment was completed between 60 and 90 days as required by subsection (e) of the standard. If applicable, the facility must submit to the Auditor any transgender detainee files that arrive at KNSPC during the CAP period. If applicable, the facility must submit to the Auditor 10 sexual abuse investigation files and the corresponding reassessments that occur during the CAP period.

Corrective Action Taken:

(a)(b)(e): The facility submitted a revised Processing Officer 1 Post Order which states, "Processing 1 Officer will complete the initial assessment (Risk Classification Assessment & Special Vulnerability Questionnaire) to determine any detainee vulnerabilities and utilize the information gained from the initial risk assessment to properly identify those detainees likely to be sexual aggressors or sexual abuse victims and make the appropriate housing determinations to mitigate any danger of sexual abuse. If detainees are identified to be LEP, limited hearing, deaf, blind or have low vision, Processing 1 Officer shall notify IHSC and the facility's Disability coordinator to ensure that the detainees' vulnerabilities are appropriately document and addressed via proper interpretation/communication devices and/or services (Communication Boards, sign language services, LEP translation services, etc." The facility submitted four samples of staff training confirmations which states, "I acknowledge that I have been trained on the updated "in processing special vulnerability" classification process, "that ensures detainees who are LEP are assessed to identify those detainees who may be sexual abuse victims or aggressors in a manner that all detainees can understand. I will take into consideration the PREA intake screening when determining a detainee initial housing, recreation or other activities and volunteer programming." The facility submitted an email reminding the Processing Officers of the standard requirements which include, the initial classification process is to be completed within twelve hours of admission into the facility, officers shall use the information obtained in the risk assessment/PREA questionnaire when determining housing, recreation and other activities and volunteer work, the facility is required to consider the information obtained during the initial risk screening to ensure the necessary steps are taken to mitigate any dangers identified in the assessment when determining a detainee initial housing. In addition, the responsive email indicated the Processing Officers had reviewed and understood the email. The facility submitted a training memo to all investigators with a signed acknowledgement which confirmed all investigators have received training on the standards requirement to reassess all detainees following an incident of sexual abuse. During the on-site revisit the facility submitted four detainee files, to include detainees who do not speak English, and one transgender detainee file which confirmed the initial risk assessment was completed within 12 hours in a manner all detainees can understand. During the on-site revisit the facility submitted four detainee files and one transgender detainee file that confirmed a reassessment was completed between 60 and 90 days as required by subsection (e) of the standard. The facility uploaded the four detainee files and one transgender detainee file reviewed during the on-site CAP revisit to the 115.41 CAP folder. The facility submitted a memorandum to Auditor which confirmed the facility has not had any closed sexual abuse allegation investigations which occurred following the on-site revisit. Upon review of all submitted documentation the APM and Auditor now find the facility in substantial compliance with subsections (a), (b), and (e) of the standard.

§115.42 - Use of assessment information

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

Notes:

(a)(b)(c): KNSPC policy 2.2, Custody Classification System, states," These assignment of housing, recreation, volunteer work and other activities shall be based on the information from the risk assessment. The facility shall make individualized determinations about how to ensure the safety of each detainee. When making assessment and housing decisions for a transgender or intersex detainee, the facility shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. The facility should not

base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. The facility's placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming. Assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee." KNSPC policy 4.5, Personal Hygiene, states, "When operationally feasible, transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." An interview with a Classification Officer confirmed detainee housing is determine based on the detainee's custody level which is determined by the criminal history and background information provided to the facility through the ICE RCA. The Classification Officer further confirmed detainees are housed with other detainees of the same custody level. In addition, the Classification Officer confirmed he reviews the In-Processing Special Vulnerability Questionnaire; however, the answers stated on the questionnaire are not considered and would not change the custody level of the detainee or where they are initially housed or their recreation or other activities, or volunteer programming. The Classification Officer further indicated transgender or intersex detainees would initially be housed in the medical unit pending medical staff input regarding the best options for housing that would ensure the health and safety of the detainee. Interviews with the MCD, one RN, and a mental health provider, indicated they are consulted prior to a transgender or intersex detainee being placed into a housing unit, programs, or other activities. The MCD, one RN, and a mental health provider further indicated, a transgender detainee would be housed in the medical area, until the determination for housing is made which would be within 24 hours and not the 12 hours required by standard 115.41. In an interview with the Classification Officer, it was indicated if a detainee is identified as a sexual predator, a potential victim of sexual abuse, or a transgender/intersex detainee, a vulnerability risk would be entered into the Risk Classification Assessment (RCA); however, a review of the RCA for two transgender detainees confirmed the RCA stated there were "no vulnerabilities". In an interview with the Classification Officer, it was further indicated all detainees, including transgender/intersex detainees are reclassified at 60/90/120 days, ensuring the transgender or intersex detainees are reassessed every six months. In interviews with four random AGS staff it was indicated transgender and intersex detainees have the opportunity to shower separately from other detainees utilizing individual showers. The Auditor reviewed two transgender detainee files and confirmed a reassessment had been completed as required by the standard.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. An interview with a Classification Officer confirmed detainee housing is determine based on the detainee's custody level which is determined by the criminal history and background information provided to them through the ICE RCA. An interview with the Classification Officer further confirmed he reviews the In-Processing Special Vulnerability Questionnaire; however, the answers stated on the questionnaire are not considered and would not change the custody level of the detainee, where they are initially housed, recreation or other activities, or volunteer programming. To become compliant, the facility must implement a practice that takes into consideration the PREA intake screening when determining a detainee's initial housing, recreation or other activities, and volunteer programming. Once implemented the facility must provide the Auditor with documentation that confirms all Classification staff have been trained on the new practice. In addition, the facility must submit to the Auditor 10 files of detainees who arrived at KNSPC during the CAP period to confirm the PREA intake screening was considered when determining a detainee's initial housing, recreation or other activities, and volunteer programming.

Corrective Action Taken:

(a): The facility submitted the "Voluntary Work Program Volunteer Worker Screening Form" which indicates "the above detainee is being considered for work assignment in the Voluntary Work Program. Please conduct a review of his detention A-File, Special Vulnerabilities/PREA Questionnaire prior to his assignment." The facility submitted an email reminding the Processing Officers of the standard requirements which include, the initial

classification process is to be completed within twelve hours of admission into the facility, officers shall use the information obtained in the risk assessment/PREA questionnaire when determining housing, recreation and other activities and volunteer work, the facility is required to consider the information obtained during the initial risk screening to ensure the necessary steps are taken to mitigate any dangers identified in the assessment when determining a detainee initial housing. The responsive email indicated the Processing Officers had reviewed and understood the email. The facility submitted 10 samples of Volunteer Worker Screening Form which indicates the staff review the Special Vulnerabilities/PREA Questionnaire prior to assigning a detainee to the Voluntary Work Program. The facility submitted one PREA risk screening and the corresponding housing email which confirms the facility took into consideration information received from the initial risk screening to ensure the necessary steps were taken to mitigate any dangers identified in the assessment when determining a detainee's initial housing. Upon review of all available information the APM and Auditor now find the facility in compliance with subsection (a) of the standard.

§115.43 - Protective Custody

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

Notes:

(a)(b)(c)(d)(e): KNSPC policy 2.12, Special Management Unit, states, "The Krome SPC shall develop and follow written procedures, consistent with this policy, governing the management of its administrative segregation unit. These procedures should be developed in consultation with the Field Office Director having jurisdiction for the facility. These procedures must document detailed reasons for placement of an individual in administrative segregation, to include potential vulnerability to sexual abuse or assault. Detainees and the Field Office Director (FOD) (or his designee) must be provided a copy of the administrative segregation order." KNSPC policy 2.12 further states, "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, as a last resort. The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Detainees in administrative segregation for protective custody shall have access to programs, visitation, counsel and other services available to the general population to the maximum extent practicable." In addition, KNSPC policy 2.12 states, "A supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted" and "a supervisor shall conduct an identical review after the detainee has spent 7 days in administrative segregation, and weekly after the first 7-day review for the first 60 days and every 10 days thereafter, at a minimum." The Auditor reviewed the Interim Checklist for Review of Segregation Placement Decisions. The checklist states, "The facility administrator, or ICE personnel, must notify the FOD within 72 hours of initial placement of any detainee in segregation…status as a sexual assault victim, or other special vulnerability…" The checklist further states, "Consider whether a less restrictive housing or custodial option is appropriate and available, and, in coordination with ICE headquarters, when necessary, arrange for utilization of such less restrictive options." In addition, the checklist further requires "a supervisory staff member shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted and at a minimum, conduct an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter. A review of KNSPC policy 2.11 confirms that the policy requires supervisors to conduct reviews every seven days for the first 60 days as opposed to the standard and checklist requirement of every seven days for the first 30 days. An interview with the OIC indicated detainees vulnerable to sexual abuse or assault would only be placed into administrative segregation after all reasonable efforts had been made to provide other appropriate housing. The OIC further indicated that detainees housed in administrative segregation for protective custody could participate in all programs, services and any other services offered to the general population. An

interview with an AGS line staff who supervises detainees in administrative segregation confirmed detainees placed in administrative segregation for protective custody have access to programs, services, visitation, counsel, and other services available to the general population. The facility PAQ indicated one detainee had been placed in administrative segregation based on a vulnerability to sexual abuse or assault. The Auditor reviewed the detainee's file and confirmed available documentation noted the detainee had been placed into protective custody at the detainee's request; however, the documentation did not include detailed reasons for the placement. In addition, a review of the detainee's file did not confirm reasonable efforts had been made to provide appropriate housing or that the placement was for the least amount of time practicable, and as a last resort as no other viable housing options existed. A review of the detainee file further confirmed the FOD had been notified of the placement within 72 hours as required by the standard. The Auditor reviewed the weekly reviews of the detainee's placement in administrative segregation and confirmed a review had been completed at 72 hours and every 7 days thereafter until the detainee was released from protective custody at 143 days. Interviews with the AFOD, OIC, and the PSA Compliance Manager indicated the KNSPC policy 2.21 was developed in consultation with the FOD.

Recommendation: The Auditor recommends that the facility Interim Checklist for Review of Segregation Placement Decisions be revised to mirror the review requirements noted in KNSPC policy 2.14.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. The facility PAQ indicated one detainee had been placed in administrative segregation based on a vulnerability to sexual abuse or assault. The Auditor reviewed the detainee's file and confirmed available documentation noted the detainee had been placed into protective custody at the detainee's request; however, the documentation did not include detailed reasons for the placement. In addition, a review of the detainee's file did not confirm reasonable efforts had been made to provide appropriate housing or that the placement was for the least amount of time practicable, and as a last resort. To become compliant, the facility must submit documentation that confirms all supervisors were retrained on the standard's requirements to document detailed reasons for the placement of an individual in administrative investigation on the basis of vulnerability to sexual abuse and to ensure reasonable efforts had been made to provide appropriate housing and made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. In addition, if applicable, the facility must forward all documentation of any detainee's placement into protective custody based on a vulnerability to sexual abuse or assault that occurs during the CAP period.

Corrective Action Taken:

(a)(b): The facility submitted the Krome SPC Refresher Training curriculum which includes the standard's requirements to document detailed reasons for the placement of an individual in administrative investigation on the basis of vulnerability to sexual abuse and to ensure reasonable efforts had been made to provide appropriate housing and made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. In addition, a review of the submitted refresher training confirms the refresher training includes a statement "I acknowledge that I have reviewed and understand the PREA Refresher training material provided by the facility to include the specific provisions below." The facility submitted five acknowledgements which confirm supervisors have received and understand the training. The facility submitted a memo to Auditor which confirms the facility has not placed any detainees into protective custody based due to being vulnerable to sexual abuse or assault which occurred following the on-site CAP revisit. Upon review of all submitted documentation the APM and Auditor now find the facility in substantial compliance with subsections (a) and (b) of the standard.

§115.51 - Detainee Reporting

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

Notes:

(a)(b)(c): KNSPC policy 2.11 states, "Krome SPC shall provide instructions on how detainees may contact their consular official, the DHS Office of Inspector General, or as appropriate, another designated office, to confidentially and, if desired, anonymously report these incidents. Krome SPC shall inform the detainees of at least one way for detainees to report sexual abuse to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous upon request. Staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." During the on-site audit, the Auditor observed postings in English and Spanish that advised the detainees how to contact their consular officials, the DHS OIG and the DRIL, to confidentially and if desired anonymously report an incident of sexual abuse. Instructions for calling the numbers were provided, in English and Spanish only, and were seen by the telephones in all housing units. With the help of a detainee and his pin number, the Auditor called the facility PREA Hotline number and left a message. A supervisor immediately came to the unit. The system sends all supervisors and the PSA Compliance Manager an email as soon as the message is left. The Auditor, a facility AGS security line staff member, and an officer from the ICE Compliance Unit, attempted to call the consular, the DHS OIG and DRI; however, all calls were unsuccessful. The Auditor could not confirm if the issue was with the phone or if the instructions provided to the detainees are incorrect. A review of the facility detainee handbook (Local Supplement) confirmed detainees are provided multiple ways to report an incident of sexual abuse, which include tell any staff member, file a grievance, tell an ICE ERO staff member, report to DHS OIG, or Ice Headquarters with numbers provided. In addition, the handbook informs the detainee they can report without giving their name. In interviews with Intake staff, it was indicated upon arrival at the facility the detainees are given the facility handbook (Local Supplement) and sign a document indicating they have received it; however, APM observation confirmed detainees are required to sign for the facility detainee handbook (Local Supplement) prior to receipt: and therefore, the Auditor could not confirm the detainees receive the information they sign for. In addition, the APM observed the intake process of a detainee whose preferred language was Russian. After several attempts to read the information to the detainee Intake staff attempted to utilize the Lionsbridge language line; however, the interpreter could not hear them and eventually hung up. In an interview with the Intake Officer, it was confirmed the detainee would receive the ICE National Detainee National Handbook in Russian; however, would only receive the facility handbook (Local Supplement) and the PREA information sheet in English as they were not available in Russian. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was English despite the detainee's insistence that his preferred language was Russian. In interviews with four random AGS security staff it was confirmed they were aware of the standards' requirement to accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports. Interviews with 20 detainees confirmed they could articulate multiple ways to report sexual abuse and they could anonymously report if desired. The Auditor reviewed 10 sexual abuse allegation investigation files and confirmed all reported incidents of sexual abuse were accepted and documented accordingly.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed information that advised the detainees how to contact their consular officials, the DHS OIG, and the DRIL, in English and Spanish only, to confidentially and if desired anonymously report an incident of sexual abuse; however, the Auditor, a facility security line staff member, and an officer from the ICE Compliance Unit, attempted to call the consular office, the DHS OIG and the DRIL and all calls were unsuccessful. To become compliant, the facility must submit documentation that confirms instructions on how to contact the DHS OIG and the DRIL were provided to all detainees in a manner all detainees can understand including those who

do not need speak English, Spanish, Mandarin, Haitian Creole or Arabic. In addition, the facility must provide the Auditor with documentation that confirms all provided detainee phone numbers are in good working order.

Corrective Action Taken:

(a)(b): The facility submitted Telephone Serviceability Worksheets to confirm the numbers provided for DHS OIG and DRIL are in good working order. The facility submitted the ICE National Detainee Handbook (English Version) which informs the detainees how to contact the DHS OIG and DRIL. During the on-site CAP revisit the APM toured the intake area and confirmed the facility has translated PREA education to include the information noted in the facility detainee handbook into numerous languages encountered by ICE. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsections (a) and (b) of the standard.

§115.53 - Detainee access to outside confidential support services

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(d): KNSPC policy 2.11 states, "The OIC shall maintain or attempt to enter into memoranda of understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime. The facility shall enable reasonable communication between detainees and these organizations and agencies, in as confidential a manner as possible. The facility shall also inform detainees, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." A review of the facility handbook confirmed the handbook did not contain information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers. The Auditor reviewed a memorandum to the file, which states, "ICE Health Service Corps is in the processing of securing a Memorandum of Understanding (MOU) agreement with the Jackson Hospital and Roxcy Bolton Rape Treatment Center to provide services to sexual assault victims. The MOU is pending final review and approval." The facility provided the Auditor with a Flyer for the RBRTC. The flyer states, "24/7 Crisis and Sexual Assault Helpline" and provides a telephone number; however, a review of the RBRTC flyer confirms it does not include the organizations address. During the on-site audit, the Auditors did not observe the flyer posted on the housing unit bulletin boards; however, the Auditors observed a piece of paper in the housing units that included the name of the local rape crisis center, RBRTC and their telephone number with no other information provided. Utilizing the detainee telephone, and without utilizing a PIN, the Auditor called the number and was connected to an advocate with RBRTC. Prior to the advocate answering the call, the telephone system did inform the detainee that the call may be monitored; however, did not inform the detainee the extent to which reports of abuse would be forwarded to authorities in accordance with mandatory reporting laws. In an interview with the RBRTC advocate it was confirmed the facility and RBRTC are in the process of establishing an MOU. The interview with the advocate further confirmed advocates provide crisis intervention, counseling, and the prosecution of sexual abuse perpetrators to most appropriately address the victims' needs. Interviews with 20 random detainees, confirmed none of detainees interviewed were aware of RBRTC, or other outside services, that may be available to them for crisis intervention or emotional support services in dealing with sexual abuse.

Corrective Action:

(c)(d): The facility is not in compliance with subsections (c) and (d) of the standard. A review of the facility handbook confirmed the handbook did not contain information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers. In addition, during the on-site audit, the Auditors observed a piece of paper in the housing units that included the name of the local rape crisis center, RBRTC, and a telephone number: however, the piece of paper did not include the

organization's address. During the on-site audit the Auditor completed a call to RBRTC and confirmed the telephone system did inform the detainee that the call may be monitored; however, did not inform the detainee the extent to which reports of abuse would be forwarded to the authorities in accordance with mandatory reporting laws. Interviews with 20 detainees, confirmed none of the detainees interviewed were aware of RBRTC, or other outside services that are available to them for crisis intervention or emotional support services in dealing with sexual abuse. To become compliant, the facility must provide documentation that confirms detainees are provided a mailing address to RBRTC or contact information to another organization in a manner that all detainees can understand including those who do not speak English, Spanish, Mandarin, Haitian Creole and Arabic. In addition, the facility must submit documentation that confirms all detainees are notified the extent to which reports of abuse would be forwarded to authorities in accordance with mandatory reporting laws including those who do not speak English, Spanish, Mandarin, Haitian Creole and Arabic.

Corrective Action Taken:

(c)(d): The facility submitted a revised Orientation Video transcript in English and Russian, which includes the address and telephone number of the Roxcy Bolton Rape Treatment Center and the statement, "Be advised All reporting to ROXCY may be subject to monitoring and reporting to law enforcement." During the on-site CAP revisit the facility provided documentation to confirm the facility has translated the Roxcy Bolton Rape Treatment Center's address and telephone number and the verbiage "Be advised All reporting to ROXCY may be subject to monitoring and reporting to law enforcement" in multiple languages encountered by ICE. The facility submitted a copy of an updated LEP form which gives the detainee the option to waive "continuing in English" as opposed to his preferred language and to waive the information gained form the orientation video in his preferred language; however, the standard requires the facility provide the detainee information about local organizations that can assist detainees who have been victims of sexual abuse including mailing addresses and toll-free telephone numbers in a manner all detainees can understand; and therefore, the updated practice does not meet the standard. The facility submitted copies of the orientation video viewed by the APM on-site translated in Arabic, Hindi, Mandarin, Portuguese, and Russian. The facility submitted an updated Special Circumstances Detainee Orientation Acknowledgement Form for a detainee with limited reading skills which states, "AGS officers have read in my language to me." The facility submitted a copy of an updated LEP form completed by a detainee of Polish decent who indicated his preferred language was English; however, the facility submitted a copy of the information regarding the Roxcy Bolton Rape Treatment Center given to the detainee in Polish; and therefore, the Auditor could not confirm the facility implemented a practice which requires the facility to provide the detainee information about local organizations that can assist detainees who have been victims of sexual abuse including mailing addresses and toll-free telephone numbers in a manner all detainees can understand. The facility uploaded copies of the orientation video viewed by the APM on-site translated in Arabic, Hindi, Mandarin, Portuguese, and Russian in the 115.53 CAP folder. Upon review of all submitted documentation, or lack thereof, the APM and Auditor continue to find the facility does not meet subsections (c) and (d) of the standard.

§115.61 - Staff and Agency Reporting Duties

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

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable

mandatory reporting law; and to document his or her efforts taken under this section." KNSPC policy 2.11 states, "Krome SPC shall require 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 such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The facility shall review and approve policies and procedures to ensure that the facility's appropriate reporting procedures are specified, including a method by which staff can report outside of the chain of command." Staff members who become aware of alleged sexual abuse shall immediately follow the reporting requirements set forth in the facility's written policies and procedures." KNSPC policy 2.11 further states "Apart from such reporting, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, make medical treatment, investigation, law enforcement, or other security and management decisions. If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the facility shall report that information to the Field Office Director so that the agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws." During interviews with all ICE, AGS, and STG International contractor staff, it was confirmed all could articulate their responsibilities to immediately report any knowledge, suspicion, or information they may receive regarding sexual abuse, retaliation for reporting or cooperating with an allegation, and any staff neglect that may have contributed an incident of sexual abuse. All ICE, AGS, and STG International contractor staff further indicated that all information regarding an incident of sexual abuse was to remain confidential and only shared with those that have a need-to-know. In addition, all ICE, AGS, and STG International contractor staff indicated they could make a report outside of their chain of command utilizing the OIG DHS number posted in the housing units or they could call the AGS staff Hotline. An interview with the facility PSA Compliance Manager confirmed he was aware of the requirements to report allegations involving a vulnerable adult to the Adult Protection Services. Interviews with the AFOD and the OIC confirmed all KNSPC policies and procedures have been approved by the Agency. KNSPC does not house juveniles or family detainees.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. During interviews staff reported they could make a report outside of their chain of command utilizing the DHS OIG number posted in the housing units or they could call the AGS staff Hotline to report misconduct; however, subsection (a) requires the facility policy to include a method by which staff can report outside the chain of command. To become compliant, the facility must revise KNSPC policy 2.11 to include a method by which staff can report outside of the chain of command. Once revised the facility must resubmit KNSPC policy 2.11 to the Agency for review and approval.

Corrective Action Taken:

(a): The facility submitted an updated KNSPC policy 2.11 which states, "Staff members who become aware of alleged sexual abuse shall immediately follow the reporting requirements set forth in the facility's written policies and procedures. To report outside of the chain of command, staff should utilize OPR and JIC contact info on page 24 of this policy." The Auditor reviewed page 24 and confirmed both OPR and JIC contact information is included. A review of KNSPC policy 2.11 further confirms the updated policy contains information to indicate the policy has been reviewed and approved by the AFOD. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsection (a) of the standard.

§115.65 - Coordinated Response

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

Notes:

(a)(b)(c)(d): KNSPC policy 2.11 states, "This policy must mandate zero tolerance toward all forms of sexual abuse or assault, outline the facility's approach to preventing, detecting, and responding to such conduct and

include, at a minimum: Plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. If a victim of sexual abuse is transferred between detention facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services. If a victim is transferred from a DHS immigration detention facility to a non-DHS facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. If the receiving facility is unknown to the sending facility, the sending facility shall notify the Field Office Director, so that he or she can notify the receiving facility. The Krome SPC 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." A review of KNSPC policy 2.11 confirms it is utilized as the facility's coordinated response plan and does indicate a multidisciplinary team approach for coordinating the actions taken by first responders, investigators, medical/mental health personnel and the facility leadership in response to an incident of sexual abuse. Interviews with the OIC and the PSA Compliance Manager indicated that medical staff would inform the receiving facilities of the detainee's potential need for services. An interview with a facility RN indicated all detainees are required to sign a consent for treatment during their initial visit with medical or mental health staff; and therefore, should a detainee be transferred to a facility not covered by the DHS PREA standards, the facility could inform the receiving facility of the incident and the victim's potential need for medical or social services regardless of if the detainee requests otherwise. However, by requiring the detainee to consent to treatment at KNSPC does not indicate they are permitted to share an incident of sexual abuse or the victim's potential need for medical or social services should the alleged detainee victim request otherwise.

Corrective Action:

(d): The facility is not in compliance with subsection (d) of the standard. An interview with a facility RN indicated all detainees are required to sign a consent for treatment during their initial visit with medical or mental health staff; and therefore, should a detainee be transferred to a facility not covered by the DHS PREA standards, the facility could inform the receiving facility of the incident and the victim's potential need for medical or social services regardless of if the detainee requests otherwise. However, by requiring the detainee to consent to treatment at KNSPC does not indicate they are permitted to share an incident of sexual abuse or the victim's potential need for medical or social services should the alleged detainee victim request otherwise. To become compliant, the facility must submit documentation that all medical and mental health staff are trained in the standard's requirement if a victim is transferred from a DHS immigration detention facility to a facility not covered by subsection (c) of this standard, the sending facility shall as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. If applicable the facility must submit all detainee sexual abuse allegation investigation files that include detainees who have been transferred from KNSPC during the CAP period.

Corrective Action Taken:

(d): The facility submitted 6 samples of acknowledgment to confirm medical staff have received training by signing the acknowledgement which states, "I acknowledge that I have reviewed and understand the PREA Refresher training material provided by the facility to include the specific provisions below." PREA standard 115.65 (d) is included; and therefore, the Auditor accepts staff training for compliance; and therefore, no longer requires the facility submit all detainee sexual abuse allegation investigation files which include detainees who have been transferred from KNSPC due to an incident of sexual abuse during the CAP period. Upon review of all submitted documentation the APM and Auditor now find the facility in substantial compliance with subsection (d) of the standard.

§115.67 - Agency protection against retaliation

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

Notes:

(a)(b)(c): Agency policy 11062.2 mandates, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." KNSPC Policy 2.11 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. Krome SPC shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. For at least 90 days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. Krome SPC shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." An interview with the PSACompliance Manager/Retaliation Monitor indicated that detainees would be monitored for up to 90 days for retaliation following an allegation of sexual abuse. The PSA Compliance Manager/Retaliation Monitor further indicated he does not meet with the detainee; however, he reviews housing changes, programming changes, and disciplinary reports. In addition, in an interview with the PSA Compliance Manager/Retaliation Monitor it was confirmed he could not articulate, without prompting from the Auditor, what protective measures would be reviewed for staff. In an interview with the PSA Compliance Manager/Retaliation Monitor it was further confirmed the PSA Compliance Manager/Retaliation Monitor could not articulate what emotional support services were available for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with a sexual abuse allegation investigation. The Auditor reviewed the facility Retaliation Monitoring log and could not confirm monitoring of detainees had been conducted or what protection measures had been reviewed as the log suggests after the initial response to possible retaliation detected there appears to be no further monitoring. In addition, a review of the log confirmed it did not include documentation to confirm monitoring of staff to include negative performance reviews or reassignments of staff as required by the standard.

Corrective Action:

(b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. An interview with the PSA Compliance Manager/Retaliation Monitor confirmed during the monitoring period he does not meet with the detainee; however, he reviews housing changes, programming changes, and disciplinary reports. In addition, in an interview with the PSA Compliance Manager/Retaliation Monitor it was confirmed he could not articulate what protective measures would be reviewed for staff or what emotional support services were available for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with an investigation. The Auditor reviewed the facility Retaliation Monitoring log and could not confirm monitoring of detainees had been conducted or what protection measures had been reviewed. A review of the log further confirmed the initial response to possible retaliation is noted; however, further monitoring could not be confirmed. In addition, a review of the log confirmed it did not include documentation to suggest the possible monitoring of staff to include, but not limited to, a review of negative performance reviews or reassignments of staff as required by the standard. The Auditor reviewed the Retaliation Monitoring log and could not confirm emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations had been offered. To become compliant, the facility must submit documentation to confirm the development of a process to monitor staff for retaliation and to act promptly to remedy any such retaliation as required by KNSPC policy 2.11 and the standard. Once implemented the facility must train all staff involved in retaliation monitoring on the new process. In addition, if applicable, the facility must provide the Auditor with five sexual abuse

allegation investigation files, and the corresponding Retaliation Monitoring log, to include both detainees and staff, to confirm retaliation monitoring was conducted and continued for at least 90 days as required by subsections (b) and (c) of the standard.

Corrective Action Taken:

(b)(c): The facility submitted three investigator samples of a Krome SPC PREA Investigator Training Update. A review of the training confirms standard 115.67 is included. In addition the form includes an acknowledgement which states, "I acknowledge that I have reviewed and understand the PREA Refresher training material provided by the facility to include the specific provisions below and I agree to employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations as needed. Additionally for at least 90 days following a report of sexual abuse, I shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. This monitoring shall continue beyond 90 days if the initial monitoring if needed." the facility submitted the revised facility PREA Retaliation Monitoring Sheet which confirms it includes the Detainee/Staff name and asks the detainee if they are experiencing any problems from other detainees or staff since reporting the charges and do you feel safe at the facility. The form also includes asking staff if they are experiencing any problems for other staff/others since reporting the charges and do you feel safe. The form requires the detainee/staff signature. The facility submitted the detainee monitoring spreadsheet. The Auditor reviewed the spreadsheet and confirmed monitoring would begin the day of a report of sexual abuse and will continue for at least 90 days. The facility submitted documentation to confirm all staff involved in retaliation monitoring have received training on the standard's requirement. The facility submitted the Retaliation Monitoring log and the corresponding PREA Monitoring Sheet which included detainees who made sexual abuse allegations following the on-site revisit. The Auditor reviewed the submitted documentation and confirmed the facility has implemented a monitoring system as required by subsections (b) and (c) of the standard. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsections (b) and (c) of the standard.

§115.73 - Reporting to detainees

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

Notes:

KNSPC policy 2.11 states, "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." An interview with the facility PSA Compliance Manager indicated that detainees are notified in writing of the results of the investigation. The Auditor reviewed 10 investigation files and submitted the "Notification of PREA Investigation Results to the Detainee" to ERO POC for confirmation of the notification. The Auditor received confirmation that seven out of 10 detainee victims were notified of the results of the investigation and 3 were not in ICE custody when the investigation closed. However, in one substantiated investigation, although the Agency notified the detainee victim of the outcome of the investigation, the Agency did not notify the victim of the responsive action that had been taken by the facility.

Corrective Action:

The facility is not in compliance with this standard. The Auditor reviewed one substantiated investigation and confirmed, although the sexual abuse allegation was substantiated, the Agency did not notify the victim of the responsive action taken by the facility following the substantiated determination. To become compliant, the Agency must implement a practice to ensure a detainee victim is notified of the results of an investigation, and any responsive action taken by the facility. If applicable, the facility must submit to the Auditor all closed sexual

abuse allegation investigation files where the determination was substantiated, and the corresponding notification to detainee, that occurred during the CAP period.

Corrective Action Taken:

The facility submitted a revised DHS Investigative Finding and Responsive Actions Notification which includes "Actions taken against (subject) if found substantiated." The facility submitted a memorandum to Auditor which confirms the facility has not had any closed sexual abuse allegation investigations which occurred following the on-site revisit. Upon review of all submitted documentation the APM and Auditor now find the facility in substantial compliance with standard 115.73.

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

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

Notes:

(a)(b)(c): IHSC 8.6.2C states, "If the assessment pursuant to (6 CFR§ 115.41) indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." Interviews with the facility MCD and a RN indicated during the medical intake, medical staff will review the In-Processing Special Vulnerability Questionnaire and will complete their own medical assessment, which includes a PREA assessment. If the medical staff become aware a detainee has experienced prior sexual victimization or perpetrated sexual abuse in the past, medical intake staff will set an appointment for a medical assessment to be completed within 2 days and will offer mental health services to the detainee. If the detainee refuses, the refusal is documented. If the detainee agrees to be seen by mental health, an electronic message is sent immediately to mental health staff for an assessment." KNSPC policy 4.3, Medical Care, states, "If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate." An interview with a mental health provider employed by STG International, indicated should a detainee be referred to mental health due to a history of sexual abuse, the detainee will be seen that day or the following day if the referral was made during the night. The mental health provider further indicated detainees referred to mental health who have been identified as sexual aggressors are assessed and offered treatment plans; however, they must be willing to participate. In addition, the mental health provider indicated any refusals for mental health services are documented in the detainee medical file. In interviews with a facility RN and a mental health provided it was indicated they have not had a detainee disclose prior sexual abuse during intake or disclose they have committed prior sexual abuse during the audit period. A review of the medical PREA assessment indicates medical staff inquiry about prior sexual abuse within the last six months; however, in interviews with the MCD and a RN it was indicated a detainee who experienced prior victimization would be seen by medical within two working days of the assessment and offered mental health services regardless of when the abuse occurred. The Auditor interviewed three detainees who had previously experienced sexual abuse. Each detainee stated they had not been offered mental health services and two of the detainees indicated they had to put in a self-referral to be seen by mental health staff. The Auditor reviewed the three detainee files and confirmed one detainee was not seen and two detainees were seen by mental health due to their request and not as a result of a referral during intake screening. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the

interpreter could not hear them and eventually hung up: and therefore, the screening was not completed in manner that would guarantee the detainee would understand the screening questions that pertain to a history of sexual victimization or a history of perpetrating sexual abuse. The Auditors reviewed 44 detainee files and confirmed only one detainee had been identified as having a history of sexual abuse. A review of the detainee's file confirmed the detainee was offered a follow-up evaluation with medical and mental health staff. In addition, a review of the medical and mental health files confirmed the detainee was seen by medical staff within two working days; however, refused a mental health follow-up.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. A review of the medical PREA assessment indicates medical staff inquiry about prior sexual abuse within the last six months; however, in interviews with the MCD and a RN it was indicated a detainee who experienced prior victimization would be seen by medical within two working days of the assessment and offered mental health services regardless of when the abuse occurred. The Auditor reviewed the medical and mental health files of three detainees who during their interview indicated they had previously experienced sexual abuse and although two of the detainees requested mental health services none of the detainees were referred to mental health during the intake process. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the interpreter could not hear them and eventually hung up: and therefore, the screening was not completed in manner that would guarantee the detainee would understand the screening questions that pertain to a history of sexual abuse or a history of perpetrating sexual abuse. To become compliant, the facility must submit documentation confirming all Intake, Classification, medical, and mental health staff have been retrained on the standard's requirement to immediately refer all detainees to medical or mental health for a follow-up, as appropriate, who have been identified during intake to have experienced sexual victimization or perpetrated sexual abuse utilizing the initial PREA risk assessment pursuant to standard 115.41. If applicable, the facility must submit to the Auditor 10 detainee files, and the corresponding medical and mental health records, that include detainees who have been identified during the initial assessment to have experienced sexual victimization or perpetrated sexual abuse, including detainees where the sexual abuse victimization or the sexual abuse was perpetrated outside of the previous six months.

Corrective Action Taken:

(a): The facility submitted a PREA Refresher Training which includes PREA standards 115.41 and 115.81. The refresher training includes a statement "I acknowledge that I have reviewed and understand the PREA Refresher training material provided by the facility to include the specific provisions below." PREA standards 115.41 (a)(b)(c) and 115.81 (a) are included. In addition, the facility has provided sample documentation to confirm five medical and mental health staff and five intake/classification staff have completed the training. The facility submitted the files of two detainee sexual abuse perpetrators, the corresponding referrals, and mental health files which confirm the facility has implemented a practice to immediately refer all detainees to medical or mental health for a follow-up, as appropriate, who have been identified during intake to have experienced sexual victimization or perpetrated sexual abuse utilizing the initial PREA risk assessment pursuant to standard 115.41. Upon review of all submitted documentation the APM and Auditor now find the facility in compliance with subsection (a) of the standard.

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

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

Notes:

(a)(b)(c)(e)(f): IHSC 8.6.2C states, "If any slight form of penetration (vaginal, oral, or anal) occurred, the detainee is tested for sexual transmitted disease if needed. Prophylactic treatment, emergency contraception and follow-up examinations for sexually transmitted diseases shall be offered to all victims." KNSPC policy 2.11 states, "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. 1. Access to emergency medical and mental health services (a) 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. (b) Where evidentiary or medically appropriate, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination, in accordance with the requirements of "M. Investigation, Discipline and Incident Reviews" of this standard. (c) Transportation of an alleged victim for emergency care or other services provided off-site shall be arranged in a manner that takes into account the special needs of victimized detainees. 2. Ongoing medical and mental health care for sexual abuse victims and abusers (a) Each facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. (b) 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. (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care. (d) 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. (e) Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. (f) 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." Interviews with the facility MCD, an RN, and a mental health provider employed by STG International indicated detainees would receive timely emergency access to medical and mental health treatment that includes 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 in accordance with professionally accepted standards of care. Interviews with the MCD, an RN and mental health provider further detainee victims of sexual abuse are offered tests for sexually transmitted infections and the services are provided at no cost to the detainee regardless of the detainee victim naming the abuser or cooperating with an investigation. An interview with a mental health provider employed STG International indicated the facility would attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning about the sexual history and treatment would be offered. The Auditor attempted to interview a representative from Jackson Memorial Hospital; however, no one returned the call. The Auditor reviewed 10 investigation files and confirmed, all detainees who reported an allegation of sexual abuse had been immediately seen by medical and mental health.

(d): KNSPC only houses adult male detainees. Therefore, this subsection is not applicable to the facility.

(g): IHSC 8.6.2C states, "A BHP, or physician if no BHP is available, should attempt to conduct a mental health evaluation of all known patient-on-patient sexual abusers, and provide treatment within 60 days of notification of such history of abuse and/or assault. If the provider successfully conducts an evaluation, the BHP or physician documents the evaluation and ensures it is placed in the electronic health record." An interview with a mental

health provider employed by STG International, indicated that if a referral is received, the detainee will be seen that day or if at night, would be seen the following day. In interviews with the MCD, an RN, and a mental health provider employed by STG International it was indicated they have not had a detainee disclose that they have committed prior sexual abuse during the audit period; however, the APM reviewed a substantiated detainee-on-detainee investigation and could not confirm a referral had been made for the abuser to be seen by mental health staff.

Corrective Action:

(g): The facility is not in compliance with subsection (g) of the standard. The APM reviewed a substantiated detainee-on-detainee investigation and could not confirm a referral had been made for the abuser to be seen by mental health staff for a mental health evaluation. To become compliant, the facility must submit documentation to confirm all facility Investigators are retrained on the standard's requirement to refer all known detainee-on-detainee abusers to mental health within 60 days of learning of such abuse so that mental health treatment can be offered in accordance with subsection (g) of the standard. If applicable, the facility must submit all detainee files, and the corresponding mental health files, that include detainees identified as detainee-on-detainee abusers utilizing the information gained from the initial PREA risk assessment. In addition, if applicable, the facility must submit all substantiated sexual abuse allegation investigation files, and the corresponding mental health records, that include detainee-on-detainee sexual abuse that occur during the CAP period.

Corrective Action Taken:

(g): The facility submitted the Krome SPC PREA Investigator Training Update which includes PREA Standard 115.83. In addition, the training, includes "I acknowledge that I have received and understand the PREA Refresher training material provided by the facility to include the specific provisions below." And "I understand the need to refer all known detainee-on-detainee abusers for mental health evaluations within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." In addition, the facility submitted signed acknowledgements which confirm all facility investigators have received the training. The facility submitted a memo to Auditor which confirmed the facility did not receive any detainees identified as detainee-on-detainee abusers utilizing the information gained from the initial PREA risk assessment or any substantiated sexual abuse allegation investigation files which included substantiated detainee-on-detainee sexual abuse which occurred following the on-site CAP revisit. Upon review of all submitted documentation the APM and Auditor now find the facility in substantial compliance with subsection (g) of the standard.

§115.86 - Sexual abuse incident review

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

Notes:

(a)(b): KNSPC policy 2.11 states, "Krome SPC 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. Unfounded allegation means an allegation that was investigated and determined not to have occurred. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the ICE PSA Coordinator. The facility shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility." The Auditor reviewed the facility Sexual Abuse or Assault Incident Review Form and confirmed the form includes the names of all the review team members present during the review, a brief summary of the incident, incident review findings, and

recommendations. A review of the Sexual Abuse or Assault Incident Review Form further confirms the incident review finding section includes whether the review team considered whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. During an interview with the PSA Compliance Manager/Lead Reviewer it was indicated the facility has established an incident review team, which includes the AGS upper management, the PSA Compliance Manager, SDDO, a facility Investigator, the Assistant PREA Coordinator and a representative from medical and mental health, an incident review is conducted on all sexual abuse allegation investigations within 30 days of the completion of the investigation, and a written report is completed. The Auditor reviewed an email to the Agency PSA Coordinator that confirms incident review reports, and the response is forwarded as required by subsection (a) of the standard. The Auditor reviewed 10 investigation files and confirmed a review had been completed within 30 days of the conclusion of the investigation.

(c): KNSPC policy 2.11 states, "Krome SPC shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, Field Office Director or his or her designee, for transmission to the ICE PSA Coordinator." The Auditor reviewed the facility 2022 Facility Annual Sexual Abuse and Assault Report and documentation to confirm the report had been forwarded to the FOD and the Agency PREA Coordinator; however, no documentation was reviewed to indicate the annual report had been forwarded to the OIC. A review of the annual report further indicates although facility PREA Allegation Spreadsheet confirmed there were 11 allegations reported at the facility in 2022, only 1 of the 11 allegations reported to have occurred during for the year 2022 occurred that year and 10 listed allegations occurred following the date the annual review was conducted. In addition, a review of the annual report indicates there were no recommendations made during or at the review; however, the Auditor reviewed a review of one investigation and confirmed there was a recommendation made by the Sexual Incident Review Team.

Corrective Action:

(c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed the annual report and confirmed although the facility PREA Allegation Spreadsheet confirmed there were 11 allegations reported at the facility in 2022, only 1 of the 11 allegations reported to have occurred during for the year 2022 occurred that year and 10 listed allegations occurred following the date the annual review was conducted. In addition, a review of the annual report indicates there were no recommendations made during or at the review; however, the Auditor reviewed a review of one investigation and confirmed there was a recommendation made by the Sexual Incident Review Team. To become compliant, the facility must resubmit the 2022 annual report to include those sexual abuse allegation investigations that were reported in the year 2022. In addition, the report must include all recommendations made by the review team and forwarded to the facility OIC, FOD, and the Agency PREA Coordinator.

Corrective Action Taken:

(c): The facility submitted the 2022 annual report which confirmed it includes sexual abuse allegation investigations reported in the year 2022, recommendations made by the review team, and was forwarded to the facility OIC, FOD, and the Agency PREA Coordinator. Upon review of all available information the APM and Auditor now find the facility in compliance with subsection (c) of the standard.

AUDITOR CERTIFICATION:

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

Robin Bruck 4/30/2024

Auditor's Signature & Date

(b) (6), (b) (7)(C) 4/30/2024

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 5/1/2024

Assistant Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	7/11/2023	**To:**	7/13/2023
AUDITOR INFORMATION			
Name of auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Miami		
Field Office Director:	Garrett Ripa		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	865 SW 78th Avenue Plantation, FL 33324		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Krome North Service Processing Center		
Physical address:	18201 Southwest 12Th Street Miami Florida 33194		
Telephone number:	305-207-2211		
Facility type:	SPC		
PREA Incorporation Date:	5/29/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Assistant Field Office Director
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	305-207-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention & Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	305-207-

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 Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of Krome North Service Processing Center (KNSPC) was conducted July 11, 2023, through July 13, 2023, by U.S. Department of Justice (DOJ) and DHS Certified PREA Auditors, Robin M. Bruck, Lead Auditor and Jodi L. Upshaw, Support Auditor, both employed by Creative Corrections, LLC. The Auditors were provided guidance and review during the audit report writing and review process by U.S. Immigration and Customs Enforcement (ICE) PREA Contract Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C), both DOJ and DHS Certified PREA Auditors. The APM accompanied the audit team and provided guidance during the on-site audit. The PM's role is to provide oversight for the ICE PREA audit process and liaison with ICE Office of Professional Responsibilities (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility compliance with the DHS PREA Standards. KNSPC is owned by ICE and operated by Akima Global Services (AGS) and is located in Miami, Florida. The audit period is between January 30, 2021, and July 13, 2023. This is the facilities third PREA audit.

Approximate 30 days prior to the on-site audit, ERAU Inspections and Compliance Specialist (ICS) and Team Lead (TL) (b) (6), (b) (7)(C) provided the Auditor with the facility Pre-Audit Questionnaire (PAQ), Agency policies, facility's policies, and other supporting documentation through the ICE SharePoint. The PAQ, policies, and supporting documentation had been organized utilizing the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into folders for ease of auditing. The main policy that governs KNSPC's PREA Program is the KRO policy 2.11, Sexual Abuse and Assault Prevention and Intervention, (SAAPI). All documentation, policies, and the facility PAQ were reviewed by the Auditor. In addition, the Auditor reviewed the Agency website (www.ice.gov/prea) and the facility website (https://www.ice.gov/detain/detention-facilities/krome-north-service-processing-center).

KNSPC processes detainees who are pending immigration review or deportation. The facility houses adult male detainees with high, medium, or low custody levels, KNSPC does not house females, juveniles or family detainees. The PAQ indicates 2391 detainees have been booked into the facility in the last 12 months. The average length of stay in custody is 52 days. According to the PAQ, the top three nationalities held at KNSPC are from Cuba, Mexico, and Honduras. On the first day of the on-site audit the facility reported 587 detainees were housed at the facility including 2 transgender detainees.

An entrance briefing was held in the KNSPC training room on Tuesday, July 11, 2023, at 8:15 a.m. The ICE ERAU TL opened the briefing. In attendance were:

(b) (6), (b) (7)(C), Section Chief (SC), ICE/OPR/ERAU
(b) (6), (b) (7)(C), TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), Detention and Deportation Officer (DDO), Compliance Unit, ICE
(b) (6), (b) (7)(C), DDO, Compliance Unit, ICE
(b) (6), (b) (7)(C), DDO, Compliance Unit, ICE
(b) (6), (b) (7)(C), DDO, Compliance Unit, ICE
(b) (6), (b) (7)(C), DDO, Compliance Unit, Unit
(b) (6), (b) (7)(C), DDO, Compliance Unit, ICE
(b) (6), (b) (7)(C), Facility Healthcare Program Manager, ICE Health Service Corps (IHSC)
(b) (6), (b) (7)(C), APM, AGS
(b) (6), (b) (7)(C), Quality Assurance Manager, AGS
(b) (6), (b) (7)(C), Assistant Health Services Administrator, IHSC, ICE

(b) (6), (b) (7)(C) Detention Service Compliance Officer, Headquarter Unit, ICE
(b) (6), (b) (7)(C) PM, AGS
(b) (6), (b) (7)(C) APM, AGS
(b) (6), (b) (7)(C) Assistant Field Office Director (AFOD), ICE/OPR
(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), Prevention of Sexual Assault (PSA) Compliance Manager, ICE/ OPR
(b) (6), (b) (7)(C), PREA Investigator, AGS
(b) (6), (b) (7)(C), DDO, Compliance Unit, ICE
(b) (6), (b) (7)(C), DDO, Compliance Unit, ICE
(b) (6), (b) (7)(C), APM, AGS
(b) (6), (b) (7)(C), APM, Certified DOJ/DHS Auditor, Creative Corrections, LLC
Robin M. Bruck, Certified DOJ/DHS Auditor, Creative Corrections, LLC
Jodi L. Upshaw, Certified DOJ/DHS Auditor, Creative Corrections, LLC

The Auditor introduced herself and provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the general knowledge of staff at all levels employed at the facility. She further explained compliance with the PREA standards will be determined based on a review of the policies and procedures, observations made during the facility on-site visit, documentation review, and interviews conducted with staff and detainees.

An on-site tour was conducted by the Auditors and the APM with key staff from AGS and ICE. All housing units utilized by ICE detainees were viewed, as well as program areas, booking/intake, recreation areas, and medical areas. All areas of the facilities where detainees are afforded the opportunity to go or are provided services were observed by the Auditors. During the tour, the Auditors made visual observations of the housing units including bathrooms and shower areas, officer post sight lines and (b) (7)(E). Sight lines were closely examined, as was the potential for blind spots, throughout areas where detainees are housed or have access. There were no notable blind spots observed by the Auditors. The two-story administration building is comprised of a lobby and reception area, (b) (7)(E), 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 a 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 trailer designed to serve as a hold room, multipurpose building used as a library and chapel area, and another building that contains administrative offices, including those of the Grievance Officer (GO) and Chaplain. In the center of the facility are recreation yards and a covered recreation area. KNSPC utilizes (b) (7)(E) surveillance cameras, that operate 24/7. Cameras have pan, tilt and zoom (PTZ) capabilities. Video footage can be (b) (7)(E) days. The video cameras are monitored in the (b) (7)(E) and (b) (7)(E) by AGS (b) (7)(E) officers, ERO, and facility AGS security staff. During the on-site audit, the Auditors observed the camera placement as well as the capabilities of each camera and confirmed staff are unable to zoom into individual cells without causing distortion. In areas, where a (b) (7)(E) or (b) (7)(E) was in view of the (b) (7)(E), a black square had been digitally added to obstruct the view. Auditors observed opposite gender announcements being made as opposite gender staff entered the housing areas. The DHS-prescribed sexual assault awareness notice, methods for reporting sexual misconduct, and victim advocacy contact information was posted in both English & Spanish, languages that are most prevalent in the facility, on bulletin boards, and on the walls in the housing units. However, the postings were not strategically located within close proximity to the detainee telephones, making it difficult for detainees to dial the phone numbers without being observed by others. The Auditors spoke to random staff and detainees regarding PREA education and the facility practices during the on-site

tour. Reviews of the facility comprehensive guidelines and the housing unit logbooks were conducted to verify rounds were being conducted by both security line staff and supervisory staff. The Auditors observed the Audit Notice posted in the housing units. No correspondence had been received prior to the on-site audit, during the on-site audit, or after the on-site audit was completed. In addition, the Auditors tested the posted telephone numbers to determine if they were in good working order. Successful calls were made to the facility PREA Hotline and the victim advocacy line; however, attempted test calls to DHS OIG, the Detention Reporting and Information Line (DRIL), and the consular numbers were unsuccessful.

KNSPC houses adult male detainees who are pending immigration review or deportation. The facility PAQ reported 2391 adult detainees have been booked into the facility in the past 12 months. The average length of stay in custody is 52 days. The top three nationalities of the facility population are Cuban, Mexican and Honduran. On the first day of the on-site audit, the facility held a total of 587 ICE adult male detainees, which included two transgender detainees. The facility does not house juvenile detainees, family detainees or female detainees; however, female detainees are processed through the intake area and are transported to other facilities for housing. During the on-site audit, Auditors conducted 30 detainee interviews, utilizing multiple interview protocols. Interviews included 20 random detainees, 2 transgender detainees, 4 detainees with a history of sexual abuse, 1 disabled detainee, and 3 Limited English Proficient (LEP) detainees. Each LEP interview was conducted with the use of a language line through Language Services Associates (LSA) provided by Creative Corrections, LLC. All interviews were conducted in a private setting allowing confidentiality for those participating in the interview process.

KNSPC PAQ, indicates the facility employs 563 employees, who may have reoccurring contact with detainees, consisting or 382 security staff, (254 males and 128 females); Medical and Mental Health staff (72 medical and 14 mental health) employed by IHSC, Public Health Services (PHS) and STG International. Additional staff include AGS food service. Maintenance services are provided by the Office of Federal Assistance Management (OFAM) International Management and Consulting Services and Commissary staff are employed by Japlop Enterprises, Inc. Volunteer religious services are provided by Jesuit Refugee Services, USA and the facility utilizes Talton Communications Systems for phone service. KNSPC has three shifts which include 0600-1400, 1400-2200 and 2200-0600. During the on-site audit, the Auditors conducted 26 staff interviews, utilizing various interview protocols, which included the AFOD, Officer in Charge (OIC), PSA Compliance Manager/Retaliation Monitor, 2 AGS Captains, Grievance Officer (GO), AGS Disciplinary Officer (DO), 2 AGS Intake Officers, IHSC Medical Clinic Director (MCD), 1 IHSC Registered Nurse (RN), one Behavioral Health Provider employed by STG International, Investigator, AGS Human Resource Manager (HRM), AGS Classification Officer, AGS Laundry Officer, AGS Segregation Officer, Sexual Assault Review Team member, Chaplain, 2 AGS security first line 1st responders, 1 non-custody 1st responder, and 4 random AGS security line staff. All interviews were conducted in a private setting allowing confidentiality for those participating in the interview process.

The facility PAQ reported there are two specially trained Investigators to complete all allegations of sexual abuse. The PREA Allegation Spreadsheet indicated there were 37 PREA allegations closed during the reporting period. The APM and Auditors reviewed 10 investigative files. The files reviewed included four staff-on-detainee allegations, (two unsubstantiated and two unfounded) and six detainee-on-detainee allegations, (1 substantiated, five unfounded).

An exit briefing was conducted on Thursday, July 13, 2023, at 2:15 p.m. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C), SC, ICE/OPR/ERAU
(b) (6), (b) (7)(C), TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), DDO, Compliance Unit, ICE

(b) (6), (b) (7)(C) DDO, Compliance Unit, ICE
(b) (6), (b) (7)(C) DDO Compliance Unit, ICE
(b) (6), (b) (7)(C) DDO Compliance Unit, ICE
(b) (6), (b) (7)(C) DDO Compliance Unit, ICE
(b) (6), (b) (7)(C) DDO Compliance Unit, ICE
(b) (6), (b) (7)(C) Quality Assurance Manager, AGS
(b) (6), (b) (7)(C) Health Services Administrator, IHSC, ICE
(b) (6), (b) (7)(C) PM, AGS
(b) (6), (b) (7)(C) APM, AGS
(b) (6), (b) (7)(C) Detention Service Compliance Officer, Headquarter Unit, ICE
(b) (6), (b) (7)(C) Facility Healthcare Program Manager, IHSC, ICE
(b) (6), (b) (7)(C) AFOD, ICE/OPR
(b) (6), (b) (7)(C) APM, AGS
(b) (6), (b) (7)(C) APM, AGS
(b) (6), (b) (7)(C) APM, Certified DOJ/DHS Auditor, Creative Corrections, LLC
Robin M. Bruck, Certified DOJ/DHS Auditor, Creative Corrections, LLC
Jodi L. Upshaw, Certified DOJ/DHS Auditor, Creative Corrections, LLC

The Auditor spoke briefly and informed those present that it was too early in the process to formalize a determination of compliance on each standard. The Auditor further advised she would review all documentation, interview notes, file review notes, and on-site observations to determine compliance. The Auditor thanked all facility staff for their cooperation in the audit process. The ICE ERAU TL explained the audit report process, timeframes for any corrective action imposed, and the timelines for the final report.

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: 19

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight
- §115.31 - Staff Training
- §115.34 - Specialized training: Investigations
- §115.52 - Grievances
- §115.54 - Third-party reporting
- §115.62 - Protection Duties
- §115.63 - Reporting to other Confinement Facilities
- §115.64 - Responder Duties
- §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
- §115.76 - Disciplinary sanctions for staff
- §115.77 - Corrective action for contractors and volunteers
- §115.78 - Disciplinary sanctions for detainees
- §115.82 - Access to emergency medical and mental health services
- §115.87 - Data collection
- §115.201 - Scope of Audit

Number of Standards Not Met: 21

- §115.13 - Detainee supervision and monitoring
- §115.15 - Limits to cross-gender viewing and searches
- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
- §115.17 - Hiring and promotion decisions
- §115.18 - Upgrades to facilities and technologies
- §115.21 - Evidence protocols and forensic medical examinations
- §115.32 - Other Training
- §115.33 - Detainee Education
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.43 - Protective Custody
- §115.51 - Detainee Reporting
- §115.53 - Detainee access to outside confidential support services
- §115.61 - Staff and Agency Reporting Duties
- §115.65 - Coordinated Response
- §115.67 - Agency protection against retaliation
- §115.73 - Reporting to detainees

- §115.81 - Medical and mental health screening; history of sexual abuse
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review

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.

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

Outcome: Meets Standard

Notes:

(c): KNPSC policy 2.11 states, "The facility has a zero-tolerance policy for sexual abuse and assault, which is prohibited by ICE policy and the law." KNPSC policy 2.11 further states, "This policy must mandate zero tolerance toward all forms of sexual abuse or assault, outline the facility's approach to preventing, detecting, and responding to such conduct and include, at a minimum: Procedures on preventing sexual abuse and assault, including: a. Procedures for assessing all detainees for their risk of sexual abusiveness or victimization; b. Procedures for housing detainees in accordance with their classification assessment; c. Training of all employees, contractors, and volunteers on the agency's and facility's zero tolerance policies and their responsibilities under those policies; and d. Notification to detainees of the facility's Sexual Abuse and Assault Prevention and Intervention Program." The Auditor reviewed KNSPC policy 2.11 and confirms it outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment and includes definitions of prohibited behaviors. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice posted on the bulletin boards in all housing units. Formal interviews with ICE staff, staff contractors, and AGS staff confirmed they were knowledgeable regarding the Agency and the facility's zero-tolerance policies. Interviews with the AFOD and the facility PSA Compliance Manager confirmed KNSPC policy 2.11 was referred and approved by the Agency.

(d): KNSPC policy 2.11 states, "The OIC shall designate a Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager) who shall serve as the facility point of contact for the ICE PSA Coordinator and who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures." An interview with the facility PSA Compliance Manager indicated he has sufficient time and authority to oversee the facility efforts to comply with the sexual abuse prevention and intervention policies and procedures. The PSA Compliance Manager further indicated he is the point of contact for the Agency PSA Coordinator.

Corrective Action:

No corrective action needed.

§115.13 - Detainee supervision and monitoring

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): KNSPC policy 2.10, Searches of Detainees, states, "Staff shall conduct frequent unannounced security inspections to identify and deter sexual abuse of detainees. Such inspections shall be implemented for night as well as day shifts. Staff is prohibited from alerting others that the security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility." A review of the KNSPC PAQ indicates the facility employs 382 AGS security staff, with duty hours from 0600-1400, 1400-2200 and 2200-0600, consisting of 254 males and 128 females who may have reoccurring contact with detainees. In addition, to security staff, the remaining staff consists of administration, medical, and food service. Medical and mental health services are provided to detainees through ICE IHSC, PHS, and STG International. Maintenance

services are provided by OFAM International Management and Consulting Services and Commissary staff are employed by Japlop Enterprises, Inc. Volunteer religious services are provided by Jesuit Refugee Services, USA. The PAQ further indicates there are (b) (7)(E) , with PTZ capabilities, located throughout the facility. Auditor observations confirmed the facility has sufficient supervision of detainees to protect them from sexual abuse. During the on-site audit, the Auditor reviewed the facility comprehensive supervision guidelines and confirmed they were reviewed in February 2023. The guidelines outline the responsibilities of detainee supervision including the requirement to make frequent unannounced security inspections of the unit that are not regular and routine. The APM and Auditor reviewed housing unit logbooks in the Krome Behavior Health Unit (KBHU) and Buildings (b) (7)(E) on two consecutive days in July 2023 and confirmed entries had been made that confirmed unannounced security inspections were conducted on seven out of 10 entries making the facility in substantial compliance with subsection (d) of the standard. An interview with a facility Captain indicated staff are prohibited from alerting others when unannounced rounds are occurring. Although requested, the facility did not provide the Auditor with documentation to confirm when determining staffing levels and the need for video monitoring, the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody. In addition, an interview with the OIC confirmed staffing levels are determined by the physical layout of the facility, length of stay, and the composition of the detainee population.

Corrective Action:

(c): The facility is not in compliance with subsections (c) of the standard. Although requested, the facility did not provide the Auditor with documentation to confirm when determining staffing levels and the need for video monitoring, the facility took into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody. In addition, an interview with the OIC confirmed staffing levels are determined by the physical layout of the facility, length of stay, and the composition of the detainee population. To become compliant, the facility must submit documentation that confirms the facility took into consideration when determining adequate staffing levels and the need for video monitoring, generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody.

§115.14 - Juvenile and family detainees

Outcome: Not Applicable

Notes:

(a)(b)(c)(d): A review of the facility PAQ and interviews with the OIC and PSA Compliance Manager confirmed the facility does not house juvenile detainees or family detainees; and therefore, standard 115.14 is not applicable.

Corrective Action:

No corrective action needed.

§115.15 - Limits to cross-gender viewing and searches

Outcome: Does Not Meet Standard

Notes:

(b)(c)(d): KNSPC policy 2.10 states, "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. Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances. All cross-gender pat-down searches shall be documented. When an officer of the opposite gender conducts a strip search which is observed by a staff member of the same gender as the detainee, staff shall document the reasons for the opposite-gender search in any logs used to record searches and in the detainee's detention file." The Auditor reviewed a memorandum to the file which states, "In the last 12 months the Krome Service Processing Center did not have any cross-gender pat down searches." Interviews with four random AGS security line staff confirmed cross-gender pat-down searches are not conducted at KNSPC. Interviews with four random AGS security line staff further confirmed should a cross-gender pat down search be required, due to exigent circumstances, they were aware all cross-gender pat-searches are required to be documented. During interviews with 20 random detainees, it was confirmed each detainee had a pat-down search conducted at the facility by an officer of the same gender. In addition, during the on-site audit, the Auditors observed five pat-down searches and confirmed each search had been performed by an officer of the same gender as the detainee. The facility does not house female detainees.

(e)(f): KNSPC policy 2.10 states, "Cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Facility staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches shall be documented." Interviews with four random AGS security line staff confirmed all strip searches, cross gender strip searches, and visual body cavity searches must be documented. Each staff member indicated that they have not conducted or witnessed a cross-gender strip search or a visual body cavity search at the facility. Interviews with 20 random detainees confirmed 19 have not been subject to a strip searched, or had a visual body cavity search, while housed at the facility. However, one transgender detainee reported she had been stripped search. She reported she requested the search be completed by a female officer and the request was granted. The Auditor reviewed the transgender detainee file and confirmed the strip search had been documented and was not conducted for the purpose of determining her genital characteristics.

(g): KNSPC policy 4.5, Personal Hygiene, states, "Staff of the opposite gender are prohibited from viewing detainees showering, performing bodily functions, and changing clothes. Detainees shall be provided with a reasonably private environment in accordance with safety and security needs. Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." Interviews with two female AGS security line staff indicated detainees are permitted to shower, change clothing, and perform bodily functions without being viewed by the opposite gender and that staff are required to announce their presence when entering housing units occupied by detainees of the opposite gender. In addition, during the on-site audit, the Auditors observed female staff announcing their presence when entering the unit. Interviews with 20 detainees, indicated that they are aware when female staff enter the unit. Some reported they can see the female staff when they enter the unit and others reported they will announce "female on floor". The Auditor viewed all camera views from the (b) (7)(E) and confirmed (b) (7)(E) or (b) (7)(E) could not be seen, as a black box was digitally added to prevent viewing of these areas, by the person monitoring the cameras; however, a view of the camera angles from the (b) (7)(E) confirmed detainees housed in the dorm housing units could be seen by cross gender staff when changing their clothing in their bed area. An interview with the PSA Compliance Manager indicated detainees are notified of cross gender

viewing by (b) (6), (b) (7)(C) in the facility handbook; however, a review of the facility handbook confirms detainees are not advised that they could be seen in a state of undress when changing their clothes in areas other than the bathrooms or showers. In addition to the camera angles, the Auditor observed opposite gender viewing issues while detainees performed bodily functions in the IHSC medical area cells (b) (7)(E) and the negative pressure cell (b). During the on-site audit the Auditor also observed in the KBHU, (b) (7)(E) were installed within the (b) (7)(E) to eliminate a significant blind spot; however, the mirrors allowed anyone passing by the area to view detainees in a state of undress while showering. In addition, the (b) (7)(E) showers allowed cross gender viewing of transgenders and intersex detainees when using the shower as the curtain length was inadequate.

(h): The facility is not designated as a Family Residential Unit; and therefore, subsection (h) is not applicable.

(i)(j): KNSPC policy 2.10 states, "Krome SPC shall not search or physically examine a detainee for the sole purpose of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. All strip searches shall be documented." KNSPC Policy 2.10 further states, "Security staff shall be trained in proper procedures for conducting pat searches, including cross-gender pat searches and searches of transgender and intersex detainees." Interviews with four random AGS security line staff indicated they are aware transgender and intersex detainees could not be searched or physically examined for the sole purpose of determining the detainee's gender. If there was a need to know the detainee would be taken to medical for determination. Interviews with four random AGS security line staff further indicated, they have received training in proper procedures for conducting pat-down searches, including cross-gender searches and searches of transgender/intersex detainees in a professional and respectful manner. Interviews with two transgender detainees, indicated they have had a pat-down search at the facility and stated they were allowed to choose the gender of the officer conducting the search. In addition, both transgenders interviewed stated the pat-down searches had been done professionally and respectfully. One transgender detainee reported she had been stripped searched. She further reported she requested the search be completed by a female officer and the request was granted. The Auditor reviewed the transgender detainee file and confirmed the strip search had been documented and not conducted for the purpose of determining her genital characteristics. The Auditor reviewed the AGS Detainee Searches and the ICE Cross-Gender, Transgender and Intersex Searches training curriculums and confirmed the training includes proper procedures for conducting pat-down searches, including pat-down searches conducted by the opposite gender, searches of transgender/intersex detainees, in a professional and respectful manner, consistent with security needs and the facility policy, including consideration of officer safety. The Auditors reviewed 31 staff training files that confirmed staff have completed the required training.

Corrective Action:

(g): The facility is not in compliance with subsection (g) of the standard. During the on-site audit, the Auditor viewed all camera views from the (b) (7)(E) and confirmed cross gender viewing issues when detainees in the dorm areas were changing their clothing. An interview with the PSA Compliance Manager indicated detainees are notified of cross gender viewing by (b) (6), (b) (7)(C) in the detainee handbook; however, a review of the facility handbook confirms detainees are not advised that they could be seen in the state of undress if they are changing their clothes in areas other than the bathroom or shower areas. In addition, during the on-site audit the Auditor observed opposite gender viewing issues while detainees performed bodily functions in the IHSC medical area cells (b) (7)(E) and the negative pressure cell (b) (6). During the on-site audit the Auditor also observed In the KBHU, (b) (7)(E) were installed within (b) (7)(E) to eliminate a significant blind spot; however, the mirrors allow anyone passing by the area to view detainees in a state of undress while (b) (7)(E). In addition, the (b) (7)(E) showers allowed cross gender viewing of transgenders and intersex detainees when using (b) (7)(E) as the curtain length was inadequate. To become compliant, the facility must submit documentation that confirms all detainees have the ability 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.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b): KNPSC policy 2.11 states, "The facility shall take appropriate steps to ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Such steps shall include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, (a) Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. (b) Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication with detainees with disabilities, including detainees who have intellectual disabilities, limited reading skills, or who are blind or have low vision. The facility shall take steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. In matters relating to allegations of sexual abuse, each facility shall employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. Each facility shall provide detainees with disabilities and detainees with Limited English Proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. Where practicable, provisions for written translation of materials related to sexual abuse or assault shall be made for other significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." Interviews with two AGS Intake staff indicated, during the intake process detainees are given the ICE National Detainee Handbook, and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet in their preferred language. AGS Intake staff further indicated the detainee will receive a copy of the facility detainee handbook (Local Supplement), available in English, Spanish, Mandarin, Haitian Creole, and Arabic, and will watch a PREA Video available in English, Spanish and Haitian Creole. In addition, interviews with AGS Intake staff and four random AGS security line staff indicated, if a detainee is LEP, there are staff interpreters who can interpret for those who speak Spanish. AGS Intake staff and four random AGS security line staff further indicated, if the detainee speaks a language other than Spanish, English, or Haitian Creole staff would utilize language line services provided through Lionbridge Interpretation Services. However, staff could not articulate how PREA information would be provided to detainees who are deaf or hard of hearing or who were blind or had low vision in a format they would understand. During the on-site audit the APM observed a teletypewriter (TTY) machine; however, none of the AGS Intake staff could articulate how to use the machine. In an interview with one AGS Intake Officer, it was indicated he would use the TTY machine to provide information detainees who were blind or had limited sight. In interviews with AGS Intake staff, it was further indicated if a detainee had limited reading skills, or had intellectual, psychiatric, or other disabilities staff would seek assistance from medical staff. In addition, in interviews with AGS Intake staff

it was indicated detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of PREA information; however, the APM observed during the intake processing of a detainee whose preferred language was Russian, AGS Intake staff required the detainee to sign the form, prior to receiving any written PREA information or watching the PREA portion of the video. In an interview with the processing AGS Intake Officer it was confirmed the detainee would receive the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet in his preferred language, Russian; however, he would only get the facility handbook in English. The Auditor reviewed the detainee's file and although the detainee insisted his preferred language was Russian the AGS Intake Officer noted the detainee's preferred language as English. In an interview with the AGS Intake Officer, it was confirmed he could not articulate how the information in the facility handbook would be provided to the detainee using the language line or how the detainee would receive the information available through the video. During the on-site audit the Auditor observed a facility PREA information sheet and the facility handbook in English, Spanish, Mandarin, Haitian Creole and Arabic and the ICE National Detainee Handbook in English and Spanish; however, AGS Intake staff were able to articulate their ability to print the ICE National Detainee Handbook in any of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. During the initial on-site tour, the Auditor did not observe the DHS-prescribed SAA Information pamphlets available in the 15 most prevalent languages encountered by ICE, specifically, English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese in the processing area; however, the facility located the pamphlets and the APM confirmed through observation the facility had begun distributing the pamphlet during the intake process. The Auditor observed the facility PREA information sheet on the detainee tablets; however, the sheet was only provided in English. An interview with a detainee whose preferred language was Arabic, indicated he could not read or write English or Spanish; however, he was provided a copy of the ICE National Detainee Handbook and the local facility handbook in English only. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was Arabic. The Auditors reviewed 44 detainee files and based on information provided in the files, and on-site observations, the Auditor could not confirm that detainees who were LEP, or who were deaf or hard of hearing, were blind or had low vision, or had speech, intellectual, or psychiatric difficulties had received the PREA information in a format they could understand.

(c): KNPSC policy 2.11 states, "Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." Interviews with four random AGS security line staff indicated they would not use a detainee to interpret for another detainee under any circumstances.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. In interviews with AGS Intake staff and four random AGS security line staff it was indicated, if the detainee speaks a language other than Spanish, English, or Haitian Creole staff would utilize language line services provided through Lionbridge Interpretation Services. However, staff could not articulate how PREA information would be provided to detainees who are deaf or hard of hearing or who were blind or had low vision in a format they would understand. During the on-site audit the APM observed a teletypewriter (TTY) machine; however, none of the AGS Intake staff could articulate how to use the machine. AGS Intake staff indicated detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of the PREA information; however, AGS Intake staff further indicated detainees are asked to sign the form, prior to receiving the handbooks or watching the PREA portion of video. During the on-site audit, the Auditor observed the facility handbook (Local Supplement) available in English, Spanish, Mandarin, Haitian Creole and Arabic and the facility orientation video in English, Spanish and Creole. PREA information was also observed on the detainee tablets: however, it was

only provided in English. An interview with a detainee whose preferred language was Arabic indicated, he could not read or write English or Spanish; however, he was provided a copy of the ICE National Detainee Handbook and the local facility handbook in English only. During the intake process of a detainee whose preferred language was Russian the APM observed AGS Intake staff required the detainee to sign the form, prior to receiving any written PREA information or watching the PREA portion of the video. In addition, a review of the detainee's file confirmed the AGS Intake Officer noted the detainee's preferred language as English. In an interview with the AGS Intake Officer, it was confirmed he could not articulate how the information in the facility handbook would be provided to the detainee using the language line or how the detainee would receive the information available through the video. The Auditors reviewed 44 detainee files and based on information provided in the files, and on-site observations, the Auditor could not confirm that detainees who were LEP, or who were deaf or hard of hearing, were blind or had low vision, or had speech, intellectual, or psychiatric difficulties had received the PREA information in a format they could understand. To become compliant, the facility must provide documentation that confirms all detainees have an equal opportunity to participate in or benefit from all aspects of the Agency's efforts to prevent, detect, and respond to sexual abuse including those who are LEP, have limited sight or are blind, or are hard of hearing or deaf. Once implemented the facility must submit documentation that all AGS Intake staff have been trained on the new procedures. In addition, if applicable, the facility must provide the Auditor with 10 detainee files who do not speak English, Spanish, Mandarin, Haitian Creole, and Arabic and are processed on different days to confirm the detainees are receiving PREA information in a manner all detainees can understand. In addition, if applicable the facility must submit three detainee files that include detainees who have limited sight or are blind or are hard of hearing or deaf to confirm they received PREA information in a manner they can understand. All detainee files must include detainees received during the corrective action plan (CAP) period.

(c): The facility is not in compliance with subsection (c) of the standard. Although stated in KNSPC policy 2.11 interviews with four random AGS security line staff confirmed they would not use a detainee to interpret for another detainee under any circumstances. To become compliant, the facility must submit documentation that all AGS security line staff, supervisors, and Investigators were trained on the standard's requirement in matters relating to sexual abuse, the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. In addition, if applicable, the facility must submit five sexual abuse allegation investigation files that include LEP detainee victims that were closed during the CAP period.

§115.17 - Hiring and promotion decisions

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or

administratively adjudicated to have engaged in such activity." AGS policy 201, Employment Offers, states, "The Company shall not hire or promote anyone who may have contact with detainees, and shall not enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. The Company when considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct described in (6 CFR, 115.17) in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The Company shall also impose upon employees a continuing affirmative duty to disclose any such misconduct. The Company, consistent with law, shall make its best efforts to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. Before hiring new staff, who may have contact with detainees, the Company shall conduct a background investigation to determine whether the candidate for hire is suitable for employment with the Company, including a criminal background records check. Upon request by the agency, the Company shall submit for the agency's approval written documentation showing the detailed elements of the Company background check for each staff member and the Company's conclusions. The Company shall require an updated background investigation every five years for employees who may have contact with detainees. The Company shall conduct an updated background investigation every five years for those facility staff who may have contact with detainees and who work in immigration-only detention facilities. The Company shall also perform a background investigation before enlisting the services of any contractor who may have contact with detainees. Upon request by the Company, the Company shall submit for the agency's approval written documentation showing the detailed elements of the Company's background check for each contractor and the Company's conclusions. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate. In the event the Agency contracts with a company for the confinement of detainees, the requirements of this section otherwise applicable to the agency also apply to the Company and its staff." An interview with the HMR indicated that before hiring a potential employee they must complete the Electronic Questionnaire for Investigation Processing (e-QIP) and must provide fingerprints. The HRM further indicated background checks are completed by the ICE PSU and ICE will determine suitability for hiring. In addition, the HRM indicated prior to being hired all staff and staff/contractors are required to fill out a Declaration for Federal Employment which states, "All your answers must be truthful and complete. A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you or for firing you after you begin work." The HRM further indicated, all staff and contractors are required to complete the DHS 6 Code of Federal Regulations Part 115 which asks potential staff/contractors all questions required by subsection (a) of the standard. In addition, the HRM indicated, prior to being hired all staff and contractor staff are required to sign a form which states, "I understand that a knowing and willful false response may result in a negative finding regarding my fitness as a contract employee supporting ICE. Furthermore, should my answers change at any time I understand I am responsible for immediately reporting the information to my Program Manager." The Auditor submitted names for 14 ICE staff, 14 AGS staff, 1 STG International staff, and 8 IHSC staff, to the ICE PSD PREA Audit Unit (PSU). Documentation was provided confirming all submitted names had completed a background check and all required forms prior to being hired and background rechecks were conducted every five years as required. However, although requested, no documentation was submitted to the Auditor to confirm volunteers or "other" contractors who may have contact with detainees were asked about the behaviors required by subsection (a) of the standard prior to utilizing their services. An interview with the HRM indicated that the facility does not inquire about previous sexual misconduct prior to staff promotions. The HRM further indicated information would be provided on substantiated allegations of sexual abuse involving a former employee if a request was received. An interview with the AFOD confirmed he had not been asked about previous sexual misconduct in a written application or during an interview prior to his promotion to his current position.

Corrective Action:

(a)(b): The Agency and facility are not in compliance with subsections (a) and (b) of the standard. Although requested, the facility did not provide documentation to confirm volunteers or "other" contractors who may have contact with detainees are asked about the behaviors required by subsection (a) of the standard prior to utilizing their services. An interview with the HRM confirmed the facility does not inquire about previous misconduct prior to staff promotions. In addition, an interview with the AFOD confirmed he was recently promoted to the AFOD position; however, he had not been asked about previous sexual misconduct in a written application or during an interview prior receiving the promotion. To become compliant, the facility shall establish a procedure to ensure that all volunteers or "other" contractors who have contact with detainees are asked about the prohibited behaviors per subsection (a) of the standard prior to utilizing their services. In addition, the facility must submit five volunteer and five "other" contractor records to confirm they are asked about the prohibited behaviors per subsection (a) of the standard prior to utilizing their services. In addition, if applicable, the Agency and facility must submit employee records of any employee promoted during the CAP period.

§115.18 - Upgrades to facilities and technologies

Outcome: Does Not Meet Standard

Notes:

(a)(b): KNSPC Policy 2.11 states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility shall consider the effect of the design, acquisition, expansion, or modification upon its ability to protect detainees from sexual abuse. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, the facility shall consider how such technology may enhance its ability to protect detainees from sexual abuse." The Auditor reviewed a memorandum to the file which states, "The Krome SPC facility has recently completed modifications to the bathroom facilities in the housing units. The modification consisted of adding privacy walls to the toilet areas to provide detainees with additional privacy." The Auditor reviewed an email request to make the bathrooms PREA compliant which confirmed the facility considered the effect of the design to enhance their ability to protect detainees from sexual abuse. During an interview with the facility PSA Compliance Manager, it was indicated the facility had updated the video technology in the last year. The PSA Compliance Manager further indicated he was not included or consulted regarding the placement of the cameras. In addition, the documentation provided to the Auditor could not confirm the facility took into consideration how the technology will protect the detainees from sexual abuse.

Corrective Action:

(b): During an interview with the facility PSA Compliance Manager, it was indicated the facility had updated the video technology in the last year. The PSA Compliance Manager further indicated he was not included or consulted regarding the placement of the cameras. In addition, the documentation provided to the Auditor could not confirm the facility took into consideration how the technology will protect the detainees from sexual abuse. To become compliant the facility must submit documentation that confirms when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, the facility took into consideration how such technology may enhance its ability to protect detainees from sexual abuse.

§115.21 - Evidence protocols and forensic medical examinations

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e): The Agency's policy 11062.2, outlines the Agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation

is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." KNSPC policy 2.11 states, "The facility is responsible for investigating allegations of sexual abuse involving detainees, it shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable. The facility shall consider how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victims' needs. The facility shall establish procedures to make available, to the full extent possible, outside victim services following incidents of sexual abuse. Additionally, the facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the facility shall provide these services by making available a qualified staff member from a community-based organization, or a qualified agency staff member. A qualified agency staff member or a qualified community-based staff member means an individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals. Where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility shall arrange for an alleged victim detainee to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel. As requested by a victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. To the extent that the agency is not responsible for investigating allegations of sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of PREA (CFR 115.21). To the extent that the agency is not responsible for investigating allegations of sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of PREA (CFR 115.21." Interviews with two facility AGS Captains, four random AGS security line staff, the MCD, a facility RN, and a Mental Health provider, employed by STG International, indicated they were knowledgeable of the facility's evidence protocol and the steps to be taken if there was a sexual assault of a detainee. An interview with a facility Investigator indicated the facility would conduct administrative investigations and if the allegation was criminal in nature, the facility would notify the Miami Dade Police Department (MDPD) to conduct a criminal investigation into the allegations. The facility PAQ indicated the facility did not have any allegations that had been investigated by an outside agency; however, during the review of 10 sexual abuse allegation investigation files confirmed the Hollywood Police Department (HPD) had been notified and investigated one allegation. Although requested by the Auditor, the facility did not provide documentation to confirm that a request had been made of the Miami Dade Police Department, or the Hollywood Police Department to follow the requirements of paragraphs (a)-(d) of the §115.21. An interview with the facility MCD indicated that SAFE/SANE exams are performed at the Jackson Memorial Hospital through Roxcy Bolton Rape Treatment Center (RBRTC). The facility MCD further indicated the rape treatment center would provide a victim advocate, at the request of the detainee, to provide emotional support, crisis intervention, information, and any needed referrals, during the SANE/SAFE exam and investigatory interviews. The Auditor reviewed a memorandum to the file, which states, "ICE Health Service Corps is in the processing of securing a Memorandum of Understanding (MOU) agreement with the Jackson Hospital and Roxcy Bolton Rape Treatment Center to provide services to sexually assault victims. The MOU is pending final review and approval." The Auditor attempted to contact a representative of the SANE/SAFE unit at the Jackson Memorial Hospital; however, the attempts were unsuccessful. In an interview with a RBRTC advocate it was confirmed RBRTC advocates provide crisis intervention, counseling and emotional support during SANE/SAFE exams and investigatory interviews. Interviews with the AFOD and the facility PSA Compliance Manager confirmed the protocol was developed in coordination with DHS.

Corrective Action:

(e): The facility is not in compliance with subsection (e) of the standard. The facility PAQ indicated the facility did not have any allegations that had been investigated by an outside agency; however, during the review of 10 investigations it was confirmed the HPD had been notified and investigated one allegation. An interview with a facility Investigator indicated the facility would conduct administrative investigations and if the allegation was criminal in nature the facility would notify the MDPD to conduct a criminal investigation into the allegations. Although requested by the Auditor, the facility did not provide documentation to confirm that a request had been made of the MSPD or the HPD to follow the requirements of paragraphs (a)-(d) of the standard. To become compliant, the facility must provide the Auditor with documentation that confirms the facility has requested the MDPD and HPD follow the requirements of paragraphs (a)-(d) of the standard when investigating an allegation of sexual abuse at KNSPC.

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

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): The Agency provided policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary. b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." KNSPC policy 2.11 states, "The Facility shall establish a facility protocol to ensure that each allegation of sexual abuse is investigated by the agency or facility or referred to an appropriate investigative authority. The facility will ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse. The facility, and any other investigating entities; and require the documentation and maintenance, for at least five years, of all reports and referrals of allegations of sexual abuse. The facility shall post its protocols on its Web site and make the protocol available to the public. Each facility protocol shall ensure that all allegations are promptly reported to the agency as described in this section, and, unless the allegation does not involve potentially criminal behavior is promptly referred for investigation to an appropriate law enforcement agency with the legal authority to conduct criminal investigations. The facility may separately, and in addition to the above reports and referrals, conduct its own investigation. When a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director, and, if it is potentially criminal, referred to an appropriate law enforcement agency having jurisdiction for investigation. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director, and to the local government entity or contractor that owns or operates the facility. If the incident is potentially criminal, the facility shall ensure that it is promptly referred to an appropriate law enforcement agency having jurisdiction for investigation." A review of the facility investigative protocol includes a description of the responsibilities of the Agency, the facility, and local law enforcement and requires all PREA allegation reports and referrals be documented and maintained for at least five years. In addition, a review of the facility investigative protocol requires the ICE SDDO within two hours notify the AFOD, the Joint Intake Center (JIC) and the OPR or OIG. If a criminal violation has occurred, OPR/OIG will respond and begin the investigation. The facility investigative protocol further requires the AGS investigator assist with securing the

crime scene and preservation of evidence. In addition, the facility investigative protocol requires OPR to coordinate with other law enforcement agencies to photograph, document, gather and store evidence and administrative investigations will be conducted by the AGS investigator after consultation with the appropriate investigative office with DHS and the assigned criminal investigative entity. Interviews with the facility OIC, the PSA Compliance Manager, and a facility Investigator confirmed all allegations are promptly investigated and if criminal are referred to the appropriate law enforcement agency with legal authority to conduct criminal investigations. Interviews with the facility OIC, the PSA Compliance Manager, and a facility Investigator further confirmed all allegations are reported the AFOD, JIC, OPR or the DHS OIG. The Auditor reviewed the facility PREA Allegation Spreadsheet which indicated there were 37 allegations that had been investigated and closed and confirmed ICE ERO and the JIC were notified in all cases. In addition, the Auditor reviewed 10 sexual abuse allegation investigation files and confirmed notification was made to ICE ERO and the JIC and in one investigation the HPD was notified. The Auditor reviewed both the Agency website (https://www.ice.gov/prea) and the facility website (https://www.ice.gov/detain/detention-facilities/krome-north-service-processing-center) and confirmed the Agency and facility has posted their Administrative Investigation Protocols as required by the standard.

Corrective Action:

No corrective action needed.

§115.31 - Staff Training

Outcome: Meets Standard

Notes:

(a)(b)(c): The Agency's policy 11062.5.2 states, "The Agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed training." KNSPC policy 2.11 states, "Employee training on the Krome SPC's Sexual Abuse and Assault Prevention and Intervention Program shall be included in training for all employees and shall also be included in annual refresher training thereafter and are able to fulfill their responsibilities under this standard. Training shall include: 1. The facility's zero-tolerance policies for all forms of sexual abuse; 2. Definitions and examples of prohibited and illegal sexual behavior; 3. The right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; 4. Instruction that sexual abuse or assault is never an acceptable consequence of detention; 5. Recognition of situations where sexual abuse or assault may occur; 6. How to avoid inappropriate relationships with detainees; 7. Working with vulnerable populations and addressing their potential vulnerability in the general population; 8. Recognition of the physical, behavioral, and emotional signs of sexual abuse or assault and ways to prevent and respond to such occurrences; 9. The requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee-victim's welfare, and for law enforcement/investigative purposes; 10. The investigation process and how to ensure that evidence is not destroyed; 11. Prevention, recognition, and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; 12. How to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; 13. Instruction on reporting knowledge or suspicion of sexual abuse or assault; and 14. Instruction on documentation and referral procedures of all allegations or suspicion of sexual assault." The Auditor reviewed the training curriculum and confirmed all elements required by the standard are included. Interviews with the PSA Compliance Manager and four random AGS security line staff indicated staff are required to attend PREA training on an annual basis. The Auditor was provided annual training sign-in sheets and was able to confirm all ICE and IHSC staff completed PREA training in August and September of 2022. In addition, the Auditor reviewed 29 AGS staff training files and confirmed all staff had received PREA training in 2021 and 2022. In an interview with the PSA Compliance Manager, it was indicated training is scheduled for August 2023.

Corrective Action:

No corrective action needed.

§115.32 - Other Training

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): KNSPC policy 2.11 states, "Krome SPC shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed how to report such incidents. In this paragraph "other contractor" means a person who provides services on a non-recurring basis to the facility pursuant to a contractual agreement with the agency or facility. Krome SPC must maintain written documentation verifying employee, volunteer, and contractor training." The Auditor reviewed the training curriculum and confirmed it notifies both volunteer and other contractors of the Agency and facility's zero tolerance policies and how to report an incident of sexual abuse. An interview with the facility Chaplin indicated all persons who provide religious services are volunteers and receive PREA training prior to providing services and refresher training is required annually. During the on-site audit, the facility provided the Auditor with Volunteer Training Sign-in sheets, indicating all volunteers have received PREA training for 2022; however, although requested by the APM the facility did not provide documentation to confirm maintenance staff employed by OFAM International Management Services or Commissary staff employed by Japlop Industries, both considered to be "other" contractors, received the required training.

Corrective Action:

(a)(c): The facility is not in compliance with subsections (a) and (c) of the standard. Although requested during the on-site audit the facility did not provide the Auditor with documentation that confirms maintenance staff employed by OFAM International Management Services or Commissary staff employed by Japlop Industries, both considered to be "other" contractors, received training on the Agency's and facility's zero-tolerance policy regarding sexual abuse or informed on how to report such incidents. To become compliant, the facility must provide the Auditor documentation to confirm "other" contractors have been trained on the Agency's and facility's zero-tolerance policy regarding sexual abuse and informed on how to report such incidents.

§115.33 - Detainee Education

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): KNSPC policy 2.11 states, "Following the intake process, the Krome SPC shall provide instruction to detainees on the Krome SPC's Sexual Abuse and Assault Prevention and Intervention Program and ensure that such instruction includes (at a minimum): Krome SPC's zero-tolerance policy for all forms of sexual abuse or assault; Prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual activity; Explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the Detention and Reporting Information Line (DRIL), the DHS/OIG and the ICE/OPR investigation processes; Information about self-protection and indicators of sexual abuse; Prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainees immigration proceedings; and Right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." During the on-site audit, the Auditors observed the DHS-prescribed sexual abuse and assault notice, which contained the name of the facility PSA Compliance Manager, and the phone number for RBRTC posted on housing unit bulletin boards and other various locations throughout the facility. The Auditor observed an outdated poster in the holding trailer; however, upon notification the facility immediately replaced the notice with the updated version. Interviews with two Intake staff indicated PREA orientation occurs during the intake process when detainees are given the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet in their preferred language. Intake staff further indicated the detainee will receive a copy of the facility detainee handbook (Local Supplement), and an untitled PREA handout, both available in English, Spanish, Mandarin, Haitian Creole and Arabic, and will watch a PREA Video available in English, Spanish, and Haitian Creole. In

addition, interviews with Intake staff and four random AGS security line staff, indicated if a detainee is LEP, there are staff interpreters who can interpret for those who speak Spanish and should a detainee speak a language other than Spanish, English, or Haitian Creole Intake staff would utilize the language line services provided through Lionbridge Interpretation Services. However, staff could not articulate how PREA information would be provided to a detainee who was deaf or hard of hearing or was blind or had low vision in a format they would understand. During the on-site audit the Auditor observed a TTY machine; however, none of the intake staff could articulate how to use the machine. In an interview with one Intake Officer, it was indicated staff would use the machine to provide detainees who are blind or have limited site the PREA information. In interviews with Intake staff, it was further indicated if a detainee had limited reading skills, is intellectually, psychiatric or has other disabilities, staff would seek assistance from medical staff. In addition, interviews with Intake staff indicated detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of the PREA information; however, the APM observed detainees being processed during the on-site audit and confirmed detainees are asked to sign the form prior to receiving any written PREA information or watching the PREA portion of the video. In an interview with the Classification Officer, it was confirmed the handbooks are provided to the detainee during the classification interview. During the on-site audit the Auditor observed the facility handbook in English, Spanish, Mandarin, Haitian Creole and Arabic and the ICE National Detainee Handbook in English and Spanish. However, Intake staff were able to articulate their ability to print the ICE National Detainee Handbook in any of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. In addition, the Auditor did not observe the DHS-prescribed SAA Information pamphlet in the processing area; however, the facility did locate the pamphlets and the APM confirmed, through observation, the facility had begun distributing them, during the intake process. A review of the ICE National Detainee Handbook and the facility local handbook confirmed all elements required by the standard are included in the handbooks. Interviews with 20 detainees indicated, 10 detainees had received the handbooks and 10 detainees either did not receive the handbooks or could not remember if they had received them. A review of 20 detainee detention files indicated all 20 detainees had signed the Detainee Summary indicating receipt of the documentation; however, observation during the intake process confirmed the detainee is required to sign the form prior to receiving the PREA information; and therefore, the Auditor could not confirm the information was provided to the detainee. In addition, a review of 20 detainee files indicated that in 11 of the files, the detainees completed the Detainee Summary three days, or more, after the date of intake. An interview with an Arabic detainee, indicated he could not read or write English or Spanish; however, he was provided a copy of the ICE National Detainee Handbook and the facility handbook (Local Supplement) in English only. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was Arabic. In addition, the APM observed the intake process of a detainee whose preferred language was Russian. After several attempts to read the information to the detainee Intake staff attempted to utilize the Lionsbridge language line; however, the interpreter could not hear them and eventually hung up. In an interview with the Intake Officer, it was confirmed the detainee would receive the ICE National Detainee National Handbook in Russian; however, would only receive the facility handbook (Local Supplement) and the PREA information sheet in English as they were not available in Russian. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was English despite the detainee’s insistence that his preferred language was Russian.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. Interviews with Intake staff confirmed detainees are asked to sign the Detainee Summary Form, available in English only, indicating receipt of the PREA information; however, during the observation of detainees being processed the APM observed the detainees are required to sign the form prior to receiving the PREA information or watching the PREA portion of the video; and therefore, the Auditor could not confirm the detainee is receiving orientation as required by the standard. Services. In interviews with Intake staff, it was confirmed staff could not articulate how PREA information would be provided to a detainee who was deaf or hard of hearing or was blind or had low vision. A review of 20 detainee detention files indicated all 20 detainees had signed the Detainee Summary indicating

receipt of the documentation; however, observation during the intake process confirmed the detainee is required to sign the form prior to receiving the PREA information. In addition, a review of 20 detainee files indicated that in 11 of the files, the detainees completed the Detainee Summary three days or more after the date of intake. The APM observed the intake process of a detainee whose preferred language was Russian. After several attempts to read the PREA information to the detainee staff attempted to utilize the language line; however, the interpreter could not hear them and eventually hung up. In response, staff indicated the detainee would receive the ICE National Detainee Handbook in his preferred language; however, he would receive both the facility handbook (Local Supplement) and PREA information sheet in English as the handbook was not available in Russian. To become compliant, the facility must provide documentation that all Intake and Classification staff are retrained on the facility orientation process. The training must include, during intake, a detainee shall not sign the Detainee Summary Form until he has received the PREA Information, including the PREA portion of the video, and completed orientation in a manner the detainee can understand. In addition, the facility must train all Intake staff on facility procedures for orientation of detainees who have limited hearing or are deaf or are blind or have low vision. The facility must provide the Auditor with 10 detainee files that include detainees who don't speak English, Spanish, Mandarin, Haitian Creole, or Arabic to confirm compliance with the standard's orientation requirements. If applicable, the facility must submit to the Auditor any detainee files that include detainees who have limited hearing or are deaf or are blind or have low vision. All detainee files must be from intake screenings that occurred during the CAP period.

§115.34 - Specialized training: Investigations

Outcome: Meets Standard

Notes:

(a)(b): The Agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. KNSPC Policy 2.11 states, "In addition to the general training provided to all facility employees, the facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training must cover, at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The facility must maintain written documentation verifying specialized training provided to investigators pursuant to this paragraph." The Auditor reviewed the 2023 Advanced PREA Investigator Lesson Plan and confirmed the curriculum includes specialized training on sexual abuse and effective cross-agency coordination. The facility PAQ indicated there are 2 facility Investigators that have received the training. The Auditor reviewed training certificates for both investigators and confirmed they have received the specialized training and have received the general PREA training as required by standard §115.31. In addition, an interview with a facility Investigator confirmed he had recently been promoted to the Investigator position. Prior to investigating an allegation, he was required to complete the specialized training. He appeared to be very knowledgeable of the steps needed to substantiate an allegation of sexual abuse.

Corrective Action:

No corrective action needed.

§115.35 - Specialized training: Medical and mental health care

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): IHSC Directive 03-01 states, IHSC has a zero-tolerance policy for sexual or physical assault, abuse, and sexual harassment. All IHSC staff receive training on the Sexual Abuse and Assault Prevention and Intervention (SAAPI) directive, PREA standards, and response protocol during initial orientation and annually thereafter throughout their employment with IHSC Training includes: 6-11-2 a Definition and examples of prohibited and illegal sexual behavior, recognizing situations where sexual abuse may occur. 6-11.2. b Detection and treatment of physically or sexually abused and assaulted detainee victims in ICE custody. 6-11.2. c Appropriate interventions when an incident occurs. 6-11.2. d Description of how to respond effectively and professionally to detainee victims of sexual abuse and assault, recognizing physical, behavioral, and emotional signs of sexual abuse. 6-11.2. e Discussion of how to communicate effectively and professionally to bisexual, transgender, intersex (LGBTI), or gender nonconforming detainee victims. 6-11.2. f Actions that will assist detainee victims to safeguard physical evidence of sexual abuse and assault. 6-11.2. g Steps for reporting allegations or suspicions of sexual abuse and assault. IHSC staff will not suffer retaliation for reporting abuse or assaults. 6-11.2. h Information for security staff on how to conduct "cross gender" pat down searches and searches of transgender and intersex detainees in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. 6-11.2. i How to identify and protect physical evidence with detainee victims, including lesbians and gays, and how to identify and protect physical evidence, victims, including lesbians and gays, and how to protect physical evidence." KNSPC policy 2.11 states, "Facility medical staff shall be trained in procedures for examining and treating detainee victims of sexual abuse in facilities where medical staff may be assigned these activities. This training shall be subject to the review and approval of the Field Officer Director or other designated ICE official." However, the standard requires the facility have a policy that includes detecting signs of sexual abuse, responding professionally to victims of sexual abuse, and proper reporting allegations of suspicions of sexual abuse. The Auditor reviewed the IHSC Training curriculum and confirmed all elements required by the standard are included in the training material. The Auditor was provided training sign-in sheets, which indicated IHSC staff have received the specialized training. In addition, the Auditor was provided documentation to confirm all IHSC staff have completed general PREA training required by §115.31. Interviews with the facility MCD and a RN confirmed all medical and mental health staff, including PHS and STG International staff are required to attend the IHSC specialized training and the facility's general PREA training. The Auditor reviewed the training file of one STG International mental health provider and confirmed the required training was received. Interviews with the AFOD and the facility PSA Compliance Manager confirmed KNSPC policy 2.11 was referred and approved by the Agency.

Corrective Action:

(c): The Auditor reviewed IHSC Directive 03-01 and confirmed it includes all the required training elements of subsection (b) of the standard; however, subsection (c) of the standard requires the facility to have a policy that requires facility medical staff not employed by IHSC to receive training on detecting signs of sexual abuse, responding professionally to victims of sexual abuse, and proper reporting allegations of suspicions of sexual abuse. To become compliant the facility must submit documentation the confirms KNSPC policy 2.11 was updated to require facility medical staff employed by PHS and STG International to receive training on detecting signs of sexual abuse, responding professionally to victims of sexual abuse, and proper reporting allegations of suspicions of sexual abuse. Once updated the facility must submit documentation to confirm the updated KNSPC policy 2.11 was referred to the Agency for review and approval.

§115.41 - Assessment for risk of victimization and abusiveness

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e): KNPSC policy 2.2, Custody Classification System, states, "The facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. Each new arrival shall be kept separate

from the general population until he/she is classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within twelve hours of admission to the facility. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: (1) Whether the detainee has a mental, physical, or developmental disability; (2) The age of the detainee; (3) The physical build and appearance of the detainee; (4) Whether the detainee has previously been incarcerated or detained; (5) The nature of the detainee's criminal history; (6) Whether the detainee has any convictions for sex offenses against adult or child; (7) Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the detainee has self-identified as having previously experienced sexual victimization; (9) The detainee's own concerns about his or her physical safety. The initial screening will take into account prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive." KNPSC policy 2.2 further states, "The detainee's risk of victimization or abusiveness will be reassessed between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." In interviews with Intake staff, it was indicated 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, how the detainee wishes to be identified (man or woman), whether the detainee has any previous convictions, whether the detainee has self-identified as having previously experienced sexual victimization, and the detainee's own concerns about his or her physical safety. A review of the RCA confirms it does not consider the detainee's physical build and appearance nor does it specifically ask the detainee if he identifies as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming or whether the detainee has any prior convictions for sexual abuse against an adult or child. In interviews with Intake staff, it was further indicated the facility utilizes a facility In-Processing Special Vulnerability Questionnaire to supplement the RCA which was updated recently. The Auditor reviewed the updated questionnaire and confirmed the questionnaire had recently been revised to specifically ask the detainee if he identifies as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; however, the revised questionnaire did not include the requirement to consider prior convictions for sex offenses against an adult or child. Interviews with the facility MCD and two RNs indicated during the medical intake, medical staff will review the In-Processing Special Vulnerability Questionnaire and will complete their own medical assessment which includes a PREA assessment. A review of the medical assessment utilized during intake confirms it captures any prior convictions for sexual abuse and the physical build and appearance of the detainee. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the interpreter could not hear them and eventually hung up: and therefore, the screening was not completed in Russian. In addition, the Auditor interviewed a detainee whose preferred language was Arabic, who indicated during the intake process he was spoken to in English only. The Auditor reviewed the detainee's file and confirmed he completed the In-Processing Special Vulnerability Questionnaire in English as the use of the language line was not documented. In interviews with the MCD, one RN, and a mental health provider it was indicated, a transgender detainee would be housed in the medical area, until a determination for housing is made, which would be within 24 hours and not the 12 hours required by the standard. The Auditors reviewed 44 detainee files and confirmed 31 detainee assessments had been completed utilizing the initial In-Processing Special Vulnerability Questionnaire prior to the questionnaire being revised for compliance. In addition, a review of 44 detainee files confirmed 8 detainees were placed in general population prior to the completion of their initial risk assessment which occurred three, or more, days after their initial intake. An interview with a facility Classification Officer indicated all detainees are reassessed at 60/90/120 day. The Classification Officer further indicated Classification staff will utilize the same vulnerability questionnaire that is used during the intake process to reassess the detainee. In addition, the

Classification Officer indicated staff meets with the detainee, utilizing the same assessment done at intake. The Classification Officer further indicated in addition to the required reassessment one would be completed based on new information or following an incident of sexual abuse or victimization; however, the APM reviewed the submitted "Recommendation/Decision Log" which noted an incident of sexual abuse reported by a detainee; however, no documentation was submitted to confirm a reassessment of the detainee victim was completed. In addition, a review of 10 investigation files could not confirm a reassessment had been completed following an incident of sexual abuse. The Auditors reviewed 44 detainee files and confirmed 13 detainees had a reassessment between 60 and 90 days, 8 had been reassessed prior to 60 days, 2 did not have documentation to indicate a reassessment had been completed, 1 had a reassessment in the file; however, it was blank, and 20 detainees had recently come into the facility and did not require a reassessment at the time of the on-site audit.

(f): KNPSC policy 2.11states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to paragraphs (c)(1), (c)(7), (c)(8) or (c)(9) of this section." During interviews with an Intake Officer, Classification Officer, and Disciplinary Officer, it was indicated detainees are not disciplined for refusing to answer questions or for not disclosing complete answers during the screening process.

(g): KNPSC policy 2.2 states "The facility shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates." An interview with the facility PSA Compliance Manager indicated all detainee files are kept in a locked cabinet.

Corrective Action:

(a)(b)(e): The facility is not in compliance with subsections (a), (b), and (e) of the standard. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the interpreter could not hear them and eventually hung up; and therefore, the screening was not completed in Russian. In addition, the Auditor interviewed a detainee whose preferred language was Arabic who indicated during the intake process he was spoken to in English only. The Auditor reviewed the detainee's file and confirmed he completed the In-Processing Special Vulnerability Questionnaire in English as the use of the language line was not documented. The Auditors reviewed 44 detainee files and confirmed 31 detainee assessments had been completed utilizing the initial In-Processing Special Vulnerability Questionnaire prior to it being revised for compliance. In addition, a review of 44 detainee files confirmed 8 detainees were placed in general population prior to the completion of their initial risk assessment which occurred three, or more, days after their initial intake. In an interview with the MCD, one RN, and a mental health provider it was indicated, a transgender detainee would be housed in the medical area, until a determination for housing was made which would be within 24 hours and not the 12 hours required by standard. An interview with the Classification Officer indicated a reassessment would be completed based on new information or following an incident of sexual abuse or victimization; however, the APM reviewed the submitted "Recommendation/Decision Log" which noted an incident of sexual abuse was reported by a detainee; however, no documentation was submitted to confirm a reassessment was completed. In addition, a review of 10 investigation files could not confirm a reassessment had been completed following an incident of sexual abuse. The Auditors reviewed 44 detainee files and confirmed out of 24 detainees who required a reassessment only 8 files confirmed the reassessment was completed within the required timeframe. To become compliant, the facility must implement a practice that ensures detainees who are LEP are assessed to identify those detainees who may be sexual abuse victims or aggressors in a manner that all detainees can understand. Once implemented the facility must submit documentation to confirm all Intake staff have been trained on the new procedure. In addition, the facility must submit documentation that all Intake and Classification staff have been retrained on the standards requirement to complete the initial assessment, and utilize the information gained from the initial risk assessment to identify those detainees likely to be sexual aggressors or sexual abuse victims, and to make housing

determinations to mitigate any danger of sexual abuse. The facility must submit documentation that confirms all Intake and Classification staff, and facility Investigators are retrained on the standards requirement to reassess all detainees following an incident of sexual abuse. The facility must submit to the Auditor 10 detainee files that include detainees who do not speak English or Spanish to confirm the initial risk assessment was completed within 12 hours and in a manner all detainees can understand. In addition, the facility must submit 10 detainee files that confirm a reassessment was completed between 60 and 90 days as required by subsection (e) of the standard. If applicable, the facility must submit to the Auditor any transgender detainee files that arrive at KNSPC during the CAP period. If applicable, the facility must submit to the Auditor 10 sexual abuse investigation files and the corresponding reassessments that occur during the CAP period.

§115.42 - Use of assessment information

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): KNSPC policy 2.2, Custody Classification System, states," These assignment of housing, recreation, volunteer work and other activities shall be based on the information from the risk assessment. The facility shall make individualized determinations about how to ensure the safety of each detainee. When making assessment and housing decisions for a transgender or intersex detainee, the facility shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. The facility's placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming. Assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee." KNSPC policy 4.5, Personal Hygiene, states, "When operationally feasible, transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." An interview with a Classification Officer confirmed detainee housing is determine based on the detainee's custody level which is determined by the criminal history and background information provided to the facility through the ICE RCA. The Classification Officer further confirmed detainees are housed with other detainees of the same custody level. In addition, the Classification Officer confirmed he reviews the In-Processing Special Vulnerability Questionnaire; however, the answers stated on the questionnaire are not considered and would not change the custody level of the detainee or where they are initially housed or their recreation or other activities, or volunteer programming. The Classification Officer further indicated transgender or intersex detainees would initially be housed in the medical unit pending medical staff input regarding the best options for housing that would ensure the health and safety of the detainee. Interviews with the MCD, one RN, and a mental health provider, indicated they are consulted prior to a transgender or intersex detainee being placed into a housing unit, programs, or other activities. The MCD, one RN, and a mental health provider further indicated, a transgender detainee would be housed in the medical area, until the determination for housing is made which would be within 24 hours and not the 12 hours required by standard 115.41. In an interview with the Classification Officer, it was indicated if a detainee is identified as a sexual predator, a potential victim of sexual abuse, or a transgender/intersex detainee, a vulnerability risk would be entered into the Risk Classification Assessment (RCA); however, a review of the RCA for two transgender detainees confirmed the RCA stated there were "no vulnerabilities". In an interview with the Classification Officer, it was further indicated all detainees, including transgender/intersex detainees are reclassified at 60/90/120 days, ensuring the transgender or intersex detainees are reassessed every six months. In interviews with four random AGS staff it was indicated transgender and intersex detainees have the opportunity to shower separately from other detainees utilizing individual showers. The Auditor reviewed two transgender detainee files and confirmed a reassessment had been completed as required by the standard.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. An interview with a Classification Officer confirmed detainee housing is determine based on the detainee's custody level which is determined by the criminal history and background information provided to them through the ICE RCA. An interview with the Classification Officer further confirmed he reviews the In-Processing Special Vulnerability Questionnaire; however, the answers stated on the questionnaire are not considered and would not change the custody level of the detainee, where they are initially housed, recreation or other activities, or volunteer programming. To become compliant, the facility must implement a practice that takes into consideration the PREA intake screening when determining a detainee's initial housing, recreation or other activities, and volunteer programming. Once implemented the facility must provide the Auditor with documentation that confirms all Classification staff have been trained on the new practice. In addition, the facility must submit to the Auditor 10 files of detainees who arrived at KNSPC during the CAP period to confirm the PREA intake screening was considered when determining a detainee's initial housing, recreation or other activities, and volunteer programming.

§115.43 - Protective Custody

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e): KNSPC policy 2.12, Special Management Unit, states, "The Krome SPC shall develop and follow written procedures, consistent with this policy, governing the management of its administrative segregation unit. These procedures should be developed in consultation with the Field Office Director having jurisdiction for the facility. These procedures must document detailed reasons for placement of an individual in administrative segregation, to include potential vulnerability to sexual abuse or assault. Detainees and the Field Office Director (FOD) (or his designee) must be provided a copy of the administrative segregation order." KNSPC policy 2.12 further states, "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, as a last resort. The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Detainees in administrative segregation for protective custody shall have access to programs, visitation, counsel and other services available to the general population to the maximum extent practicable." In addition, KNSPC policy 2.12 states, "A supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted" and "a supervisor shall conduct an identical review after the detainee has spent 7 days in administrative segregation, and weekly after the first 7-day review for the first 60 days and every 10 days thereafter, at a minimum." The Auditor reviewed the Interim Checklist for Review of Segregation Placement Decisions. The checklist states, "The facility administrator, or ICE personnel, must notify the FOD within 72 hours of initial placement of any detainee in segregation…status as a sexual assault victim, or other special vulnerability…" The checklist further states, "Consider whether a less restrictive housing or custodial option is appropriate and available, and, in coordination with ICE headquarters, when necessary, arrange for utilization of such less restrictive options." In addition, the checklist further requires "a supervisory staff member shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted and at a minimum, conduct an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter. A review of KNSPC policy 2.11 confirms that the policy requires supervisors to conduct reviews every seven days for the first 60 days as opposed to the standard and checklist requirement of every seven days for the first 30 days. An interview with the OIC indicated detainees vulnerable to sexual abuse or assault would only be placed into administrative segregation after all reasonable efforts had been made to provide other appropriate housing. The OIC further indicated that detainees housed in administrative segregation for protective custody could participate in all programs, services and any other services offered to the general population. An interview with an AGS line staff who supervises detainees in administrative segregation confirmed detainees

placed in administrative segregation for protective custody have access to programs, services, visitation, counsel, and other services available to the general population. The facility PAQ indicated one detainee had been placed in administrative segregation based on a vulnerability to sexual abuse or assault. The Auditor reviewed the detainee's file and confirmed available documentation noted the detainee had been placed into protective custody at the detainee's request; however, the documentation did not include detailed reasons for the placement. In addition, a review of the detainee's file did not confirm reasonable efforts had been made to provide appropriate housing or that the placement was for the least amount of time practicable, and as a last resort as no other viable housing options existed. A review of the detainee file further confirmed the FOD had been notified of the placement within 72 hours as required by the standard. The Auditor reviewed the weekly reviews of the detainee's placement in administrative segregation and confirmed a review had been completed at 72 hours and every 7 days thereafter until the detainee was released from protective custody at 143 days. Interviews with the AFOD, OIC, and the PSA Compliance Manager indicated the KNSPC policy 2.21 was developed in consultation with the FOD.

Recommendation: The Auditor recommends that the facility Interim Checklist for Review of Segregation Placement Decisions be revised to mirror the review requirements noted in KNSPC policy 2.14.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. The facility PAQ indicated one detainee had been placed in administrative segregation based on a vulnerability to sexual abuse or assault. The Auditor reviewed the detainee's file and confirmed available documentation noted the detainee had been placed into protective custody at the detainee's request; however, the documentation did not include detailed reasons for the placement. In addition, a review of the detainee's file did not confirm reasonable efforts had been made to provide appropriate housing or that the placement was for the least amount of time practicable, and as a last resort. To become compliant, the facility must submit documentation that confirms all supervisors were retrained on the standard's requirements to document detailed reasons for the placement of an individual in administrative investigation on the basis of vulnerability to sexual abuse and to ensure reasonable efforts had been made to provide appropriate housing and made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. In addition, if applicable, the facility must forward all documentation of any detainee's placement into protective custody based on a vulnerability to sexual abuse or assault that occurs during the CAP period.

§115.51 - Detainee Reporting

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): KNSPC policy 2.11 states, "Krome SPC shall provide instructions on how detainees may contact their consular official, the DHS Office of Inspector General, or as appropriate, another designated office, to confidentially and, if desired, anonymously report these incidents. Krome SPC shall inform the detainees of at least one way for detainees to report sexual abuse to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous upon request. Staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." During the on-site audit, the Auditor observed postings in English and Spanish that advised the detainees how to contact their consular officials, the DHS OIG and the DRIL, to confidentially and if desired anonymously report an incident of sexual abuse. Instructions for calling the numbers were provided, in English and Spanish only, and were seen by the telephones in all housing units. With the help of a detainee and his pin number, the Auditor called the facility PREA Hotline number and left a message. A supervisor immediately came to the unit. The system sends all supervisors and the PSA Compliance Manager an email as soon as the message is left. The Auditor, a facility AGS security line staff member, and an officer from the ICE Compliance Unit, attempted to call the consular, the DHS OIG and DRIL; however, all calls were unsuccessful. The Auditor could not confirm if the issue was with the phone or if the instructions provided to the detainees are incorrect. A review of the facility detainee handbook (Local Supplement) confirmed detainees are provided multiple ways to report an incident of sexual abuse, which

include tell any staff member, file a grievance, tell an ICE ERO staff member, report to DHS OIG, or Ice Headquarters with numbers provided. In addition, the handbook informs the detainee they can report without giving their name. In interviews with Intake staff, it was indicated upon arrival at the facility the detainees are given the facility handbook (Local Supplement) and sign a document indicating they have received it; however, APM observation confirmed detainees are required to sign for the facility detainee handbook (Local Supplement) prior to receipt: and therefore, the Auditor could not confirm the detainees receive the information they sign for. In addition, the APM observed the intake process of a detainee whose preferred language was Russian. After several attempts to read the information to the detainee Intake staff attempted to utilize the Lionsbridge language line; however, the interpreter could not hear them and eventually hung up. In an interview with the Intake Officer, it was confirmed the detainee would receive the ICE National Detainee National Handbook in Russian; however, would only receive the facility handbook (Local Supplement) and the PREA information sheet in English as they were not available in Russian. The Auditor reviewed the detainee's file and confirmed the preferred language form indicated the detainee's preferred language was English despite the detainee's insistence that his preferred language was Russian. In interviews with four random AGS security staff it was confirmed they were aware of the standards' requirement to accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports. Interviews with 20 detainees confirmed they could articulate multiple ways to report sexual abuse and they could anonymously report if desired. The Auditor reviewed 10 sexual abuse allegation investigation files and confirmed all reported incidents of sexual abuse were accepted and documented accordingly.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed information that advised the detainees how to contact their consular officials, the DHS OIG, and the DRIL, in English and Spanish only, to confidentially and if desired anonymously report an incident of sexual abuse; however, the Auditor, a facility security line staff member, and an officer from the ICE Compliance Unit, attempted to call the consular office, the DHS OIG and the DRIL and all calls were unsuccessful. To become compliant, the facility must submit documentation that confirms instructions on how to contact the DHS OIG and the DRIL were provided to all detainees in a manner all detainees can understand including those who do not speak English, Spanish, Mandarin, Haitian Creole or Arabic. In addition, the facility must provide the Auditor with documentation that confirms all provided detainee phone numbers are in good working order.

§115.52 - Grievances

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): KNSPC policy 6.2, Grievance System, states, "The facility shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse." KNSPC policy 6.2 further states, "The Krome SPC shall have written policy and procedures for a detainee grievance system that: Ensure procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. Medical emergencies shall be brought to the immediate attention of proper medical personnel for further assessment. Detainees shall be provided with a written or oral response within five days of receipt of the grievance. The detainee shall have the option to file an appeal if the detainee is dissatisfied with a GO decision and shall be informed of that option. The designated members of the GAB (made up of 1 SDDO and 1 Deportation Officer, not previously involved in adjudicating the grievance) shall review and provide a decision on the grievance within five days of receipt of the appeal. To prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties. Another detainee, facility staff, family member, legal representative or nongovernmental organization may assist in the preparation of a grievance with a detainee's consent." KNSPC policy 4.3, Medical Care, states, "The Krome SPC Facility shall bring all medical emergencies to the immediate attention of proper medical personnel for further assessment." A

review of the facility handbook confirmed the written procedures for time-sensitive and medical grievances are included. During the on-site audit the Auditor observed grievance boxes installed in all housing units. An interview with the GO indicated he is responsible for collecting the grievances on a daily basis and if there is an allegation of sexual abuse, the detainee will immediately be taken to medical for an assessment. The GO further indicated, detainees can file a grievance related to sexual abuse at any time with no time limits imposed and they do not have to go through the informal grievance process. In addition, the GO indicated, he would be responsible to ensure a detainee who needed assistance to file a grievance is provided the assistance requested and if a grievance includes an allegation of sexual abuse, he will respond to the detainee within five days, noting the allegation has been submitted to facility Investigators and the grievance has been closed. The facility PAQ indicated that there no grievances alleging sexual abuse, or anything related to sexual abuse; however, a review of 10 investigation files, confirmed 5 of the allegations had been received through the grievance process. A review of the sexual abuse allegation investigation files submitted through the grievance process, and the facility computerized grievance system, confirmed a response was submitted to the detainee within five days. A review of the sexual abuse allegation investigation files submitted through the grievance process further confirmed three out the five detainees who filed a sexual abuse allegation were provided medical and mental health service, at the time the grievance was filed. The Auditor reviewed the medical and mental health files of the two detainees who filed an allegation of sexual abuse through the grievance process and confirmed one detainee filed the grievance while admitted to the local hospital and medical and mental health care records of the other detainee confirmed he was offered medical services upon receipt of the grievance. The review of five sexual abuse allegation files that had been received during the grievance process confirmed none of the detainees required assistance in filing the grievance.

Corrective Action:

No corrective action needed.

§115.53 - Detainee access to outside confidential support services

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): KNSPC policy 2.11 states, “The OIC shall maintain or attempt to enter into memoranda of understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime. The facility shall enable reasonable communication between detainees and these organizations and agencies, in as confidential a manner as possible. The facility shall also inform detainees, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." A review of the facility handbook confirmed the handbook did not contain information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers. The Auditor reviewed a memorandum to the file, which states, "ICE Health Service Corps is in the processing of securing a Memorandum of Understanding (MOU) agreement with the Jackson Hospital and Roxcy Bolton Rape Treatment Center to provide services to sexual assault victims. The MOU is pending final review and approval." The facility provided the Auditor with a Flyer for the RBRTC. The flyer states, "24/7 Crisis and Sexual Assault Helpline" and provides a telephone number; however, a review of the RBRTC flyer confirms it does not include the organizations address. During the on-site audit, the Auditors did not observe the flyer posted on the housing unit bulletin boards; however, the Auditors observed a piece of paper in the housing units that included the name of the local rape crisis center, RBRTC and their telephone number with no other information provided. Utilizing the detainee telephone, and without utilizing a PIN, the Auditor called the number and was connected to an advocate with RBRTC. Prior to the advocate answering the call, the telephone system did inform the detainee that the call may be monitored; however, did not inform the detainee the extent to which reports of abuse would be forwarded to authorities in accordance with mandatory reporting laws. In an interview with the RBRTC advocate it was confirmed the facility and RBRTC are in the process of establishing an MOU. The interview with the advocate further confirmed advocates provide crisis intervention, counseling,

and the prosecution of sexual abuse perpetrators to most appropriately address the victims' needs. Interviews with 20 random detainees, confirmed none of detainees interviewed were aware of RBRTC, or other outside services, that may be available to them for crisis intervention or emotional support services in dealing with sexual abuse.

Corrective Action:

(c)(d): The facility is not in compliance with subsections (c) and (d) of the standard. A review of the facility handbook confirmed the handbook did not contain information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers. In addition, during the on-site audit, the Auditors observed a piece of paper in the housing units that included the name of the local rape crisis center, RBRTC, and a telephone number: however, the piece of paper did not include the organization's address. During the on-site audit the Auditor completed a call to RBRTC and confirmed the telephone system did inform the detainee that the call may be monitored; however, did not inform the detainee the extent to which reports of abuse would be forwarded to the authorities in accordance with mandatory reporting laws. Interviews with 20 detainees, confirmed none of the detainees interviewed were aware of RBRTC, or other outside services that are available to them for crisis intervention or emotional support services in dealing with sexual abuse. To become compliant, the facility must provide documentation that confirms detainees are provided a mailing address to RBRTC or contact information to another organization in a manner that all detainees can understand including those who do not speak English, Spanish, Mandarin, Haitian Creole and Arabic. In addition, the facility must submit documentation that confirms all detainees are notified the extent to which reports of abuse would be forwarded to authorities in accordance with mandatory reporting laws including those who do not speak English, Spanish, Mandarin, Haitian Creole and Arabic.

§115.54 - Third-party reporting

Outcome: Meets Standard

Notes:

KNPSC policy 2.11 states, "The facility shall establish a method to receive third-party reports of sexual abuse in its facility and shall make available to the public information on how to report sexual abuse on behalf of a detainee." A review of the facility website (https://www.ice.gov/detain/detention-facilities/krome-north-service-processing-center) confirmed the facility provides the public with multiple ways to report sexual abuse, retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents, on behalf of a detainee. The website provides addresses and telephone number for the DHS OIG, the DRIL, and ICE OPR. The Auditor completed the online report form for the DRIL and confirmed it was in good working order. In addition, a review of the Agency website (www.ice.gov/prea) confirmed it provides the public with information (telephone number & address) regarding third-party reporting of sexual abuse on behalf of the detainee. Interviews with the OIC, PSA Compliance Manager, and four AGS security line staff indicated they would accept a sexual abuse allegation made by a third party.

Corrective Action:

No corrective action needed.

§115.61 - Staff and Agency Reporting Duties

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable

mandatory reporting law; and to document his or her efforts taken under this section." KNSPC policy 2.11 states, "Krome SPC shall require 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 such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The facility shall review and approve policies and procedures to ensure that the facility's appropriate reporting procedures are specified, including a method by which staff can report outside of the chain of command." Staff members who become aware of alleged sexual abuse shall immediately follow the reporting requirements set forth in the facility's written policies and procedures." KNSPC policy 2.11 further states "Apart from such reporting, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, make medical treatment, investigation, law enforcement, or other security and management decisions. If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the facility shall report that information to the Field Office Director so that the agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws." During interviews with all ICE, AGS, and STG International contractor staff, it was confirmed all could articulate their responsibilities to immediately report any knowledge, suspicion, or information they may receive regarding sexual abuse, retaliation for reporting or cooperating with an allegation, and any staff neglect that may have contributed an incident of sexual abuse. All ICE, AGS, and STG International contractor staff further indicated that all information regarding an incident of sexual abuse was to remain confidential and only shared with those that have a need-to-know. In addition, all ICE, AGS, and STG International contractor staff indicated they could make a report outside of their chain of command utilizing the OIG DHS number posted in the housing units or they could call the AGS staff Hotline. An interview with the facility PSA Compliance Manager confirmed he was aware of the requirements to report allegations involving a vulnerable adult to the Adult Protection Services. Interviews with the AFOD and the OIC confirmed all KNSPC policies and procedures have been approved by the Agency. KNSPC does not house juveniles or family detainees.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. During interviews staff reported they could make a report outside of their chain of command utilizing the DHS OIG number posted in the housing units or they could call the AGS staff Hotline to report misconduct; however, subsection (a) requires the facility policy to include a method by which staff can report outside the chain of command. To become compliant, the facility must revise KNSPC policy 2.11 to include a method by which staff can report outside of the chain of command. Once revised the facility must resubmit KNSPC policy 2.11 to the Agency for review and approval.

§115.62 - Protection Duties

Outcome: Meets Standard

Notes:

KNPSC policy 2.11 states, "Staff with reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he/she shall take immediate action to protect the detainee." Interviews with the OIC and the facility PSA Compliance Manager indicated if there is a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse staff are required to take immediate action. Interviews with four AGS security line staff and two AGS Captains confirmed if they become aware a detainee is at substantial risk of sexual abuse their first response would be to protect the detainee from the danger by separating him from the alleged perpetrator. A review of 10 sexual abuse allegation investigation files confirmed once staff became aware of an imminent threat of sexual abuse the alleged detainee victim was immediately removed from the imminent danger.

Corrective Action:

No corrective action needed.

§115.63 - Reporting to other Confinement Facilities

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): KNSPC policy 2.11 states, "Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the facility whose staff received the allegation shall notify the Field Office Director and the appropriate administrator of the facility where the alleged abuse occurred. The notification provided in this section shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. The facility shall document that it has provided such notification. The facility where the alleged abuse occurred shall then ensure the allegation is referred for investigation and reported to the appropriate Field Office Director in accordance with this standard." An interview with the facility PSA Compliance Manager indicated if the facility received notification from another facility that a detainee alleged he was sexually abused while housed at KNSPC, the allegation would immediately be referred for an investigation and a notification would be made to the ICE FOD. The PSA Compliance Manager further indicated, if an allegation was received that a detainee was sexually abused while confined in another facility, he would notify the head of the facility within 72 hours; however, the notification is usually immediate. In interviews with the PSA Compliance Manager and the OIC it was indicated the notification would be made by phone and followed up with an email for documentation purposes. A review of the PREA Allegation Spreadsheet confirmed the facility has not received a sexual abuse allegation occurring at another facility, or another facility reporting an allegation that occurred at KNSPC, during the audit period.

Corrective Action:

No corrective action needed.

§115.64 - Responder Duties

Outcome: Meets Standard

Notes:

(a)(b): KNSPC policy 2.11 states, "(a) Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or his or her supervisor, shall be required to: Separate the alleged victim and abuser; Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; If the abuse and/or sexual abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; If the sexual abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. (b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." In interviews with two security first responders and one non-security first responded it was confirmed all staff interviewed were aware of their first responder responsibilities. In a review of two sexual abuse allegation investigation files that required staff perform first responder duties following an allegation of sexual abuse it was confirmed first responders' duties were carried out in accordance with the standard.

Corrective Action:

No corrective action needed.

§115.65 - Coordinated Response

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): KNSPC policy 2.11 states, "This policy must mandate zero tolerance toward all forms of sexual abuse or assault, outline the facility's approach to preventing, detecting, and responding to such conduct and include, at a minimum: Plan to coordinate actions taken by staff first responders, medical and mental health

practitioners, investigators, and facility leadership in response to an incident of sexual abuse. If a victim of sexual abuse is transferred between detention facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services. If a victim is transferred from a DHS immigration detention facility to a non-DHS facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. If the receiving facility is unknown to the sending facility, the sending facility shall notify the Field Office Director, so that he or she can notify the receiving facility. The Krome SPC 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." A review of KNSPC policy 2.11 confirms it is utilized as the facility's coordinated response plan and does indicate a multidisciplinary team approach for coordinating the actions taken by first responders, investigators, medical/mental health personnel and the facility leadership in response to an incident of sexual abuse. Interviews with the OIC and the PSA Compliance Manager indicated that medical staff would inform the receiving facilities of the detainee's potential need for services. An interview with a facility RN indicated all detainees are required to sign a consent for treatment during their initial visit with medical or mental health staff; and therefore, should a detainee be transferred to a facility not covered by the DHS PREA standards, the facility could inform the receiving facility of the incident and the victim's potential need for medical or social services regardless of if the detainee requests otherwise. However, by requiring the detainee to consent to treatment at KNSPC does not indicate they are permitted to share an incident of sexual abuse or the victim's potential need for medical or social services should the alleged detainee victim request otherwise.

Corrective Action:

(d): The facility is not in compliance with subsection (d) of the standard. An interview with a facility RN indicated all detainees are required to sign a consent for treatment during their initial visit with medical or mental health staff; and therefore, should a detainee be transferred to a facility not covered by the DHS PREA standards, the facility could inform the receiving facility of the incident and the victim's potential need for medical or social services regardless of if the detainee requests otherwise. However, by requiring the detainee to consent to treatment at KNSPC does not indicate they are permitted to share an incident of sexual abuse or the victim's potential need for medical or social services should the alleged detainee victim request otherwise. To become compliant, the facility must submit documentation that all medical and mental health staff are trained in the standard's requirement if a victim is transferred from a DHS immigration detention facility to a facility not covered by subsection (c) of this standard, the sending facility shall as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. If applicable the facility must submit all detainee sexual abuse allegation investigation files that include detainees who have been transferred from KNSPC during the CAP period.

§115.66 - Protection of detainees from contact with alleged abusers

Outcome: Meets Standard

Notes:

KNSPC policy 2.11 states, "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." An interview with the facility OIC indicated that if an allegation of sexual abuse is received involving a staff member, the staff member would be removed from all contact with detainees until the outcome of the investigation is determined. The facility OIC further stated, depending on the seriousness of the allegation, staff could be placed on administrative leave or moved to another post that does not have contact with detainees, such as the facility lobby or outside the facility perimeter. In addition, the facility OIC indicated if the alleged abuser is a contractor or volunteer, they would be removed from the facility, until the conclusion of the investigation. The Auditor reviewed 10 sexual abuse investigation files which included 4 staff-on-detainee sexual abuse allegations and confirmed staff had been reassigned to another post that did not have detainee contact, in

two of the files. The Auditor interviewed a staff contractor employed by STG International, who indicated following a detainee allegation of sexual abuse the facility immediately removed her from the facility until the completion of the investigation. The APM reviewed an email from the ICE ERAU TL that confirmed the allegation was investigated and at the conclusion of the investigation the staff contractor was allowed to return to the facility by the Agency FOD.

Corrective Action:

No corrective action needed.

§115.67 - Agency protection against retaliation

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): Agency policy 11062.2 mandates, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." KNSPC Policy 2.11 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. Krome SPC shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. For at least 90 days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. Krome SPC shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." An interview with the PSA Compliance Manager/Retaliation Monitor indicated that detainees would be monitored for up to 90 days for retaliation following an allegation of sexual abuse. The PSA Compliance Manager/Retaliation Monitor further indicated he does not meet with the detainee; however, he reviews housing changes, programming changes, and disciplinary reports. In addition, in an interview with the PSA Compliance Manager/Retaliation Monitor it was confirmed he could not articulate, without prompting from the Auditor, what protective measures would be reviewed for staff. In an interview with the PSA Compliance Manager/Retaliation Monitor it was further confirmed the PSA Compliance Manager/Retaliation Monitor could not articulate what emotional support services were available for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with a sexual abuse allegation investigation. The Auditor reviewed the facility Retaliation Monitoring log and could not confirm monitoring of detainees had been conducted or what protection measures had been reviewed as the log suggests after the initial response to possible retaliation detected there appears to be no further monitoring. In addition, a review of the log confirmed it did not include documentation to confirm monitoring of staff to include negative performance reviews or reassignments of staff as required by the standard.

Corrective Action:

(b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. An interview with the PSA Compliance Manager/Retaliation Monitor confirmed during the monitoring period he does not meet with the detainee; however, he reviews housing changes, programming changes, and disciplinary reports. In addition, in an interview with the PSA Compliance Manager/Retaliation Monitor it was confirmed he could not articulate what protective measures would be reviewed for staff or what emotional support services were available for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with an investigation. The Auditor reviewed the facility Retaliation Monitoring log and could not confirm monitoring of detainees had been conducted or what protection measures had been reviewed. A review of the log further confirmed the initial response to possible retaliation is noted; however, further monitoring could not be confirmed. In addition, a review of the log confirmed it did not include documentation to suggest the possible monitoring of staff to include, but not limited to, a review of negative performance reviews or reassignments of staff as required by the

standard. The Auditor reviewed the Retaliation Monitoring log and could not confirm emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations had been offered. To become compliant, the facility must submit documentation to confirm the development of a process to monitor staff for retaliation and to act promptly to remedy any such retaliation as required by KNSPC policy 2.11 and the standard. Once implemented the facility must train all staff involved in retaliation monitoring on the new process. In addition, if applicable, the facility must provide the Auditor with five sexual abuse allegation investigation files, and the corresponding Retaliation Monitoring log, to include both detainees and staff, to confirm retaliation monitoring was conducted and continued for at least 90 days as required by subsections (b) and (c) of the standard.

§115.68 - Post-allegation protective custody

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): KNSPC policy 2.11 states, "The Facility shall take care to place detainees of sexual abuse in a supportive environment that represents the least restrictive housing option possible (e.g., in a different housing unit, transfer to another facility, medical housing, or protective custody), and that takes into account any ongoing medical and mental health needs of the alleged victim. Victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." An interview with the OIC indicated detainee victims of sexual assault would be placed in a supportive environment that represents the least restrictive housing option possible. An interview with a facility Classification Officer indicated that a detainee will not be returned to general population until a reassessment has been completed. During the on-site audit the Auditor reviewed a sexual abuse allegation investigation file that included an alleged transgender detainee victim of sexual abuse who had been placed into protective custody at the detainee's request. The Auditor reviewed the detainee's file and confirmed the appropriate ICE FOD was notified within 72 hours of the detainee's placement in administrative segregation. The Auditor attempted to interview the detainee; however, the detainee refused to participate in the interview process.

Corrective Action:

No corrective action needed.

§115.71 - Criminal and administrative investigations

Outcome: Meets Standard

Notes:

(a)(b)(c): KNSPC policy 2.11 states, "The facility is responsible for investigating allegations of sexual abuse, all investigations into alleged sexual abuse must be prompt, thorough, objective, and conducted by specially trained, qualified investigators. When an alleged victim of sexual abuse or assault that occurred elsewhere is subsequently transferred to the detention facility, the facility shall cooperate with any administrative or criminal investigative efforts arising from the incident." KNSPC policy 2.11 further states, "Upon conclusion of a criminal investigation where the allegation was substantiated, or in instances where no criminal investigation has been completed, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. Krome SPC written procedures for administrative investigations, including provisions requiring: (i) Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; (ii) Interviewing alleged victims, suspected perpetrators, and witnesses; (iii) Reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; (iv) Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the

individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph; (v) An effort to determine whether actions or failures to act at the facility contributed to the abuse; (vi) 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 (vii) Retention of such reports for as long as the alleged abuser is detained or employed by the agency or 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, to ensure that the criminal investigation is not compromised by an internal administrative investigation." Interviews with the facility PSA Compliance Manager and a facility Investigator indicated there are two Investigators who conduct sexual abuse allegation administrative investigations at KNSPC. The Auditor reviewed the 2023 Advanced PREA Investigator Lesson Plan and confirmed the curriculum includes specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed the training records of both facility Investigator's and confirmed both investigators are qualified and have received the specialized training. The Auditor reviewed 10 investigation files and confirmed all elements required by the subsection (c) of the standard were completed.

(e)(f): KNSPC policy 2.11 states, "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. When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." An interview with a facility Investigator indicated if an allegation appeared to be criminal, he would notify the local law enforcement and would assist and cooperate with them throughout the investigation. The facility Investigator further indicated they would remain in constant contact with local law enforcement to remain aware of the progress of the investigation. In addition, the facility Investigator indicated an administrative investigation would not begin until after consultation with ICE and the local police department to ensure the case is not comprised. Interviews with the facility PSA Compliance Manager and a facility Investigator, confirmed an investigation will be completed regardless of a departure of the alleged abuser or victim from the employment or control of the facility. The Auditor reviewed 10 investigation files and confirmed all elements required by the subsections (e) and (f) of the standard were followed including notification to the HPD in one of the files.

Corrective Action:

No corrective action needed.

§115.72 - Evidentiary standard for administrative investigations

Outcome: Meets Standard

Notes:

Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse. Additionally, the ICE OPR Investigations Incidents of Sexual Abuse and Assault training required for investigators includes the evidentiary standard for administrative investigations." KNSPC policy 2.11 states, "When an administrative investigation is undertaken, the Facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated." An interview with a facility Investigator indicated the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The Auditors reviewed 10 investigative files and confirmed the outcomes of the investigations were not based on a standard higher than a preponderance of evidence.

Corrective Action:

No corrective action needed.

§115.73 - Reporting to detainees

Outcome: Does Not Meet Standard

Notes:

KNSPC policy 2.11 states, "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." An interview with the facility PSA Compliance Manager indicated that detainees are notified in writing of the results of the investigation. The Auditor reviewed 10 investigation files and submitted the "Notification of PREA Investigation Results to the Detainee" to ERO POC for confirmation of the notification. The Auditor received confirmation that seven out of 10 detainee victims were notified of the results of the investigation and 3 were not in ICE custody when the investigation closed. However, in one substantiated investigation, although the Agency notified the detainee victim of the outcome of the investigation, the Agency did not notify the victim of the responsive action that had been taken by the facility.

Corrective Action:

The facility is not in compliance with this standard. The Auditor reviewed one substantiated investigation and confirmed, although the sexual abuse allegation was substantiated, the Agency did not notify the victim of the responsive action taken by the facility following the substantiated determination. To become compliant, the Agency must implement a practice to ensure a detainee victim is notified of the results of an investigation, and any responsive action taken by the facility. If applicable, the facility must submit to the Auditor all closed sexual abuse allegation investigation files where the determination was substantiated, and the corresponding notification to detainee, that occurred during the CAP period.

§115.76 - Disciplinary sanctions for staff

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): KRO policy 2.11 states, "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 policies, rules or standards. The facility shall review and approve policies and procedures regarding disciplinary or adverse actions for staff and shall ensure that the facility policy and procedures specify disciplinary or adverse actions for staff, up to and including removal from their position and from the Federal service, when there is a substantiated allegation of sexual abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Removal from their position and from the Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer, paragraphs (1)–(4) and (7)–(8) of the CFR §115.6." Interviews with the AFOD, OIC, and the facility PSA Compliance Manager indicated staff are subject to disciplinary action up to and including termination for violations of the Agency and facility policies regarding sexual abuse. Interviews with the AFOD, OIC, and the facility PSA Compliance Manager further indicated a report would be made to local law enforcement and if determined to be substantiated a report would be made to any licensing bodies. The Auditor interviewed a staff contractor employed by STG International, who indicated following a detainee allegation of sexual abuse the facility immediately removed her from the facility until the completion of the investigation. The APM reviewed an email from the ICE ERAU TL that confirmed the allegation was investigated and at the conclusion of the investigation the staff contractor was allowed to return to the facility by the Agency FOD. A review of the PREA Allegation Spreadsheet confirms there were no substantiated allegations of sexual abuse involving staff or contractor staff sexual misconduct with a criminal nexus to demonstrate the termination, resignation, or other disciplinary actions that would be taken by the facility.

Corrective Action:

No corrective action needed.

§115.77 - Corrective action for contractors and volunteers

Outcome: Meets Standard

Notes:

(a)(b)(c): KNSPC policy 2.11 states, "Any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees. The facility shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. Such incidents shall be reported to law enforcement agencies, unless the activity was clearly not criminal. The facility shall also report such incidents to the Field Office Director 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. The facility shall take appropriate remedial measures and consider 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 PREA standards." An interview with the facility OIC indicated that contractors and volunteers who engage in sexual abuse or have violated other provisions within these standards are prohibited from contact with detainees. They would be removed from the facility pending the outcome of an investigation and the facility would ensure reasonable efforts to report removals or resignations in lieu of removal for violations of the agency or facility policies to any relevant licensing bodies. A review of the PREA Allegation Spreadsheet confirms there were no substantiated allegations of sexual abuse involving contractors or volunteers at KNSPC during the audit period.

Corrective Action:

No corrective action needed.

§115.78 - Disciplinary sanctions for detainees

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): KNSPC policy 2.11 states, "The Facility shall subject a detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse, consistent with the requirements of Policy "Disciplinary System." Krome SPC shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." KNSPC policy 3.1, Disciplinary System, states, "The Facility shall have a detainee disciplinary system with progressive levels of reviews, appeals, procedures and documentation procedures. At all steps in the disciplinary process, any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. The disciplinary process shall consider whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed." An interview with the facility AGS Disciplinary Officer indicated the facility does have a formal disciplinary process that is intended to encourage detainees to conform with rules and regulations. The AGS Disciplinary Officer further indicated the disciplinary process includes progressive levels of review, appeal procedures, documentation procedures, and includes sanctions for those who engage in prohibited acts of sexual abuse. In addition, the AGS Disciplinary Officer indicated the procedures include a review to determine if the detainee's mental disabilities contributed to the behavior and a detainee would not face disciplinary action for falsely reporting an incident or lying, even if the investigation does not establish evidence sufficient to substantiate the allegation, if the report was made in good faith. The Disciplinary Officer further indicated a detainee would not be disciplined for sexual contact with a staff member unless the staff member did not engage or consent to the contact. During a review of 10 sexual abuse allegation investigation files, the Auditor reviewed one allegation of detainee-on-detainee sexual abuse that had been substantiated. The Auditor reviewed the disciplinary record of the perpetrator and confirmed the perpetrator had been issued a disciplinary report, received a hearing, and was afforded the appeal process. A review of the sexual

abuse allegation investigation file further confirmed the sanctions imposed on the detainee were commensurate with the severity of the committed act.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): IHSC 8.6.2C states, "If the assessment pursuant to (6 CFR§ 115.41) indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." Interviews with the facility MCD and a RN indicated during the medical intake, medical staff will review the In-Processing Special Vulnerability Questionnaire and will complete their own medical assessment, which includes a PREA assessment. If the medical staff become aware a detainee has experienced prior sexual victimization or perpetrated sexual abuse in the past, medical intake staff will set an appointment for a medical assessment to be completed within 2 days and will offer mental health services to the detainee. If the detainee refuses, the refusal is documented. If the detainee agrees to be seen by mental health, an electronic message is sent immediately to mental health staff for an assessment." KNSPC policy 4.3, Medical Care, states, "If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate." An interview with a mental health provider employed by STG International, indicated should a detainee be referred to mental health due to a history of sexual abuse, the detainee will be seen that day or the following day if the referral was made during the night. The mental health provider further indicated detainees referred to mental health who have been identified as sexual aggressors are assessed and offered treatment plans; however, they must be willing to participate. In addition, the mental health provider indicated any refusals for mental health services are documented in the detainee medical file. In interviews with a facility RN and a mental health provided it was indicated they have not had a detainee disclose prior sexual abuse during intake or disclose they have committed prior sexual abuse during the audit period. A review of the medical PREA assessment indicates medical staff inquiry about prior sexual abuse within the last six months; however, in interviews with the MCD and a RN it was indicated a detainee who experienced prior victimization would be seen by medical within two working days of the assessment and offered mental health services regardless of when the abuse occurred. The Auditor interviewed three detainees who had previously experienced sexual abuse. Each detainee stated they had not been offered mental health services and two of the detainees indicated they had to put in a self-referral to be seen by mental health staff. The Auditor reviewed the three detainee files and confirmed one detainee was not seen and two detainees were seen by mental health due to their request and not as a result of a referral during intake screening. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the interpreter could not hear them and eventually hung up: and therefore, the screening was not completed in manner that would guarantee the detainee would understand the screening questions that pertain to a history of sexual victimization or a history of perpetrating sexual abuse. The Auditors reviewed 44 detainee files and confirmed only one detainee had been identified as having a history of sexual abuse. A review of the detainee's file confirmed the detainee was offered a follow-up evaluation with medical and mental health staff. In addition, a review of the medical and mental health files confirmed the detainee was seen by medical staff within two working days; however, refused a mental health follow-up.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. A review of the medical PREA assessment indicates medical staff inquiry about prior sexual abuse within the last six months; however, in interviews with the MCD and a RN it was indicated a detainee who experienced prior victimization would be seen by medical within two working days of the assessment and offered mental health services regardless of when the abuse occurred. The Auditor reviewed the medical and mental health files of three detainees who during their interview indicated they had previously experienced sexual abuse and although two of the detainees requested mental health services none of the detainees were referred to mental health during the intake process. During the on-site audit, the APM observed the intake process of a detainee whose preferred language was Russian and confirmed he could not understand the English language; however, AGS Intake staff attempted to complete the PREA risk assessment by reading the questions to the detainee in English. After several attempts, the APM observed staff attempting to utilize Lionbridge Services; however, the interpreter could not hear them and eventually hung up: and therefore, the screening was not completed in manner that would guarantee the detainee would understand the screening questions that pertain to a history of sexual abuse or a history of perpetrating sexual abuse. To become compliant, the facility must submit documentation confirming all Intake, Classification, medical, and mental health staff have been retrained on the standard's requirement to immediately refer all detainees to medical or mental health for a follow-up, as appropriate, who have been identified during intake to have experienced sexual victimization or perpetrated sexual abuse utilizing the initial PREA risk assessment pursuant to standard 115.41. If applicable, the facility must submit to the Auditor 10 detainee files, and the corresponding medical and mental health records, that include detainees who have been identified during the initial assessment to have experienced sexual victimization or perpetrated sexual abuse, including detainees where the sexual abuse victimization or the sexual abuse was perpetrated outside of the previous six months.

§115.82 - Access to emergency medical and mental health services

Outcome: Meets Standard

Notes:

(a)(b): KNSPC policy 2.11 states, "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. 1. Access to emergency medical and mental health services (a) 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." Interviews with the facility MCD, one RN, and a mental health provider employed by STG International indicated a detainee who has been victimized by sexual abuse is offered timely, unimpeded access to emergency medical treatment without financial cost and regardless of if the detainee victim cooperates with any investigation arising out of the incident. In an interview with a RBRTC advocate it was confirmed advocates provide crisis intervention services to all detainee victims of sexual abuse in accordance with professionally accepted standards of care. The Auditor attempted to interview a representative from Jackson Memorial Hospital; however, no one returned the call. The Auditor reviewed 10 sexual abuse allegation investigation files and confirmed all detainees who reported an allegation of sexual abuse had been immediately seen by medical and mental health. The facility does not house female detainees.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(e)(f): IHSC 8.6.2C states, "If any slight form of penetration (vaginal, oral, or anal) occurred, the detainee is tested for sexual transmitted disease if needed. Prophylactic treatment, emergency contraception and follow-up examinations for sexually transmitted diseases shall be offered to all victims." KNSPC policy 2.11 states, "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. 1. Access to emergency medical and mental health services (a) 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. (b) Where evidentiary or medically appropriate, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination, in accordance with the requirements of "M. Investigation, Discipline and Incident Reviews" of this standard. (c) Transportation of an alleged victim for emergency care or other services provided off-site shall be arranged in a manner that takes into account the special needs of victimized detainees. 2. Ongoing medical and mental health care for sexual abuse victims and abusers (a) Each facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. (b) 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. (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care. (d) 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. (e) Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. (f) 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." Interviews with the facility MCD, an RN, and a mental health provider employed by STG International indicated detainees would receive timely emergency access to medical and mental health treatment that includes 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 in accordance with professionally accepted standards of care. Interviews with the MCD, an RN and mental health provider further detainee victims of sexual abuse are offered tests for sexually transmitted infections and the services are provided at no cost to the detainee regardless of the detainee victim naming the abuser or cooperating with an investigation. An interview with a mental health provider employed STG International indicated the facility would attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning about the sexual history and treatment would be offered. The Auditor attempted to interview a representative from Jackson Memorial Hospital; however, no one returned the call. The Auditor reviewed 10 investigation files and confirmed, all detainees who reported an allegation of sexual abuse had been immediately seen by medical and mental health.

(d): KNSPC only houses adult male detainees. Therefore, this subsection is not applicable to the facility.

(g): IHSC 8.6.2C states, "A BHP, or physician if no BHP is available, should attempt to conduct a mental health evaluation of all known patient-on-patient sexual abusers, and provide treatment within 60 days of notification of such history of abuse and/or assault. If the provider successfully conducts an evaluation, the BHP or physician documents the evaluation and ensures it is placed in the electronic health record." An interview with a mental health provider employed by STG International, indicated that if a referral is received, the detainee will be seen that day or if at night, would be seen the following day. In interviews with the MCD, an RN, and a mental health provider employed by STG International it was indicated they have not had a detainee disclose that they have committed prior sexual abuse during the audit period; however, the APM reviewed a substantiated detainee-on-detainee investigation and could not confirm a referral had been made for the abuser to be seen by mental health staff.

Corrective Action:

(g): The facility is not in compliance with subsection (g) of the standard. The APM reviewed a substantiated detainee-on-detainee investigation and could not confirm a referral had been made for the abuser to be seen by

mental health staff for a mental health evaluation. To become compliant, the facility must submit documentation to confirm all facility Investigators are retrained on the standard's requirement to refer all known detainee-on-detainee abusers to mental health within 60 days of learning of such abuse so that mental health treatment can be offered in accordance with subsection (g) of the standard. If applicable, the facility must submit all detainee files, and the corresponding mental health files, that include detainees identified as detainee-on-detainee abusers utilizing the information gained from the initial PREA risk assessment. In addition, if applicable, the facility must submit all substantiated sexual abuse allegation investigation files, and the corresponding mental health records, that include detainee-on-detainee sexual abuse that occur during the CAP period.

§115.86 - Sexual abuse incident review

Outcome: Does Not Meet Standard

Notes:

(a)(b): KNSPC policy 2.11 states, "Krome SPC 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. Unfounded allegation means an allegation that was investigated and determined not to have occurred. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the ICE PSA Coordinator. The facility shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility." The Auditor reviewed the facility Sexual Abuse or Assault Incident Review Form and confirmed the form includes the names of all the review team members present during the review, a brief summary of the incident, incident review findings, and recommendations. A review of the Sexual Abuse or Assault Incident Review Form further confirms the incident review finding section includes whether the review team considered whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. During an interview with the PSA Compliance Manager/Lead Reviewer it was indicated the facility has established an incident review team, which includes the AGS upper management, the PSA Compliance Manager, SDDO, a facility Investigator, the Assistant PREA Coordinator and a representative from medical and mental health, an incident review is conducted on all sexual abuse allegation investigations within 30 days of the completion of the investigation, and a written report is completed. The Auditor reviewed an email to the Agency PSA Coordinator that confirms incident review reports and the response is forwarded as required by subsection (a) of the standard. The Auditor reviewed 10 investigation files and confirmed a review had been completed within 30 days of the conclusion of the investigation.

(c): KNSPC policy 2.11 states, "Krome SPC shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, Field Office Director or his or her designee, for transmission to the ICE PSA Coordinator." The Auditor reviewed the facility 2022 Facility Annual Sexual Abuse and Assault Report and documentation to confirm the report had been forwarded to the FOD and the Agency PREA Coordinator; however, no documentation was reviewed to indicate the annual report had been forwarded to the OIC. A review of the annual report further indicates although facility PREA Allegation Spreadsheet confirmed there were 11 allegations reported at the facility in 2022, only 1 of the 11 allegations reported to have occurred during for the year 2022 occurred that year and 10 listed allegations occurred following the date the annual review was conducted. In addition, a review of the annual report indicates there were no recommendations made during or at the review;

however, the Auditor reviewed one investigation and confirmed there was a recommendation made by the Sexual Incident Review Team.

Corrective Action:

(c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed the annual report and confirmed although the facility PREA Allegation Spreadsheet confirmed there were 11 allegations reported at the facility in 2022, only 1 of the 11 allegations reported to have occurred during for the year 2022 occurred that year and 10 listed allegations occurred following the date the annual review was conducted. In addition, a review of the annual report indicates there were no recommendations made during or at the review; however, the Auditor reviewed a review of one investigation and confirmed there was a recommendation made by the Sexual Incident Review Team. To become compliant, the facility must resubmit the 2022 annual report to include those sexual abuse allegation investigations that were reported in the year 2022. In addition, the report must include all recommendations made by the review team and forwarded to the facility OIC, FOD, and the Agency PREA Coordinator.

§115.87 - Data collection

Outcome: Meets Standard

Notes:

(a): KRO policy 2.11 states, "The facility shall maintain in a secure area 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, if necessary, and/or counseling in accordance with PREA standards and applicable agency policies, and in accordance with established schedules. The DHS Office of Inspector General shall maintain the official investigative file related to claims of sexual abuse investigated by the DHS Office of Inspector General." An interview with the facility PSA Compliance Manager confirmed all files related to sexual abuse are secured in his office. The Auditor toured the area during the on-site audit and confirmed files related to claims of sexual abuse are maintained in accordance with standard 115.87.

Corrective Action:

No corrective action needed.

§115.201 - Scope of Audit

Outcome: Meets Standard

Notes:

(d)(e)(i)(j): KNSPC Policy 2.11 states, "Krome SPC shall cooperate with all DHS audits of the facility's compliance with this standard, including by making available relevant documents, records, and other information as requested (including available videotapes and other electronically available data). Upon request, Krome SPC shall also provide to DHS the results of any audits conducted of the facility against the DOJ "National Standards to Prevent, Detect, and Respond to Prison Rape. Krome SPC shall permit auditors access to all areas of the facility and shall make available space suitable for interviews of detainees and staff. Detainees shall be permitted to have private interviews with auditors, and to send confidential information or correspondence to the auditor." During all stages of the audit, including the on-site audit, the Auditor was able to review available policies, memos, and other documentation required to make an assessment on PREA compliance. Interviews with detainees were conducted on-site, in private, and have remained confidential. The Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. No detainee, outside entity, or staff correspondence was received prior to the on-site audit, during the on-site audit, or following the on-site audit.

Corrective Action:

No corrective action needed.

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.

Robin Bruck 9/5/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/5/2023

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/6/2023

Assistant Program Manager's Signature & Date