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

Homeland Security

AUDITOR INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
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Name of Field Office:	Chicago Field Office		
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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Lincoln County Detention Center		
Physical address:	65 Business Park Dr., Troy, Missouri 63379		
Mailing address: *(if different from above)*			
Telephone number:	636-528-8564		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Jail Administrator
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Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Staff Sergeant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	636-528-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found Lincoln County Detention Center (LCDC) met 18 standards, had 0 standards that exceeded, had 2 standards that were non-applicable, and had 21 non-compliant standards. As a result of the facility being out of compliance with 21 standards, the facility entered a 180-day corrective action period which began on June 16, 2023, and ended on December 13, 2023. The purpose of the corrective action plan is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Initially Not Met: 21

§115.13 Detainee supervision and monitoring

§115.15 Limits to cross-gender viewing and searches

§115.17 Hiring and promotion decisions

§115.21 Evidence protocols and forensic medical examinations

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

§115.31 Staff training

§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

§115.65 Coordinated response

§115.67 Agency protection against retaliation

§115.68 Post-allegation protective custody

§115.71 Criminal and administrative investigations

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

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

§115.86 Sexual abuse incident reviews

The facility submitted documentation, through the Agency for the CAP on June 16, 2023, through December 11, 2023. The Auditor reviewed the final documentation submitted on December 19, 2023. In a review of the submitted documentation, to demonstrate compliance with the deficient standards, the Auditor determined compliance with 16 of the standards, and found that 5 standards continued to be non-complaint based on submitted documentation or lack thereof.

Number of Standards Not Met: 5

§115.17 Hiring and promotion decisions

§115.33 Detainee education

§115.35 Specialized training: Medical and Mental Health care

§115.42 Use of assessment information

§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; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "The facility ensures that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The facility administrator determines security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, the facility takes into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors." LCDC policy SAAPI further mandates, "Frequent unannounced security inspections shall be conducted to identify and deter sexual abuse of detainees. Inspections will occur on night as well as day shifts. Staff are prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility." The Auditor reviewed the facility PAQ which indicated LCDC employees 23 security staff (14 male and 9 female) with duty hours from 0500 – 1700 and 1700 – 0500. The remaining staff consists of administration, maintenance, medical, mental health contracted through Compass Health, and food service contracted through Summit Food Service. During the onsite audit, the Auditor did observe appropriate staffing levels in the intake area and medical area where detainees are housed. The intake desk is elevated to allow direct observation into the holding cells. There were monitors on the (b) (7)(E) with camera views of (b) (7)(E) and (b) (7)(E). There are a total of (b) (7)(E) located throughout the facility. Video cameras operate 24/7 and allow for sound, but do not have pan, tilt, and zoom, (PTZ) functionality. Cameras are continuously monitored by a staff member in the (b) (7)(E). Video feed can be observed on office computers located in (b) (7)(E), on the (b) (7)(E), and on the (b) (7)(E), (b) (7)(E), and (b) (7)(E). During the onsite tour, the Auditor observed adequate cameras within the (b) (7)(E), (b) (7)(E) and (b) (7)(E). The Auditor reviewed Booking Post Orders, Confinement Post Orders and Main Control Post Orders. Although these were provided for comprehensive detainee supervision guidelines and signed, they did not include a date to confirm an annual review had been conducted. During an interview, the JA indicated the Agency reviewed the comprehensive detainee supervision guidelines last month; however, no documentation was provided to confirm the review. In addition, the facility did not provide documentation to confirm when determining adequate levels of detainee supervision 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 recommendation 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 an interview with the JA, it was confirmed he could not articulate what the facility would consider in determining adequate levels of detainee supervision and the need for video monitoring. In interviews with two SSgts., it was indicated facility safety inspections were conducted every hour; however, were not documented. Therefore, as unannounced security inspections were not documented the Auditor could not confirm they were conducted in accordance with subsection (d) of the standard. In addition, although policy review confirms the facility prohibits staff from alerting others about unannounced security inspections, interviews with three random DOs could not confirm knowledge of the practice.

Does Not Meet (b)(c)(d): The facility is not in compliance with subsections (b), (c), and (d) of this standard. In an interview with the JA, it was indicated that the comprehensive detainee supervision guidelines were reviewed last month by the Agency; however, no documentation was provided to confirm the review. The facility did not provide documentation to confirm when determining adequate levels of detainee supervision 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 recommendation 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, the facility did not provide documentation that unannounced security inspections to identify and deter sexual abuse of detainees are being conducted. In interviews with three random DOs, it was confirmed they were unaware of the standards requirement not to alert other staff when unannounced security inspections are being conducted. To become compliant the facility must provide the Auditor with documentation to confirm that

LCDC's comprehensive detainee supervision guidelines have been reviewed for the year 2023. In addition, documentation must be provided to confirm when determining adequate staffing levels and the need for video monitoring, the facility took into consideration the physical layout of each holding 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. The facility must also implement a practice that requires supervisors to make frequent unannounced security inspections on both day and night shifts to identify and deter sexual abuse of detainees as required by the standard. Once implemented the facility must submit documentation to confirm all supervisors were trained in conducting unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees. The facility must submit documentation to confirm all security staff have been trained on the standards requirement not to alert others while unannounced security inspections are being conducted. The facility must submit to the Auditor documentation of unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees for each month of the Corrective Action Plan (CAP) period.

Corrective Action (b)(c)(d): The facility submitted three comprehensive supervision guidelines which confirmed the facility conducted an annual review of the comprehensive supervision guidelines on 02/12/2023. The facility submitted an email to all security staff to include security supervisors with read receipts which directed staff not alert others the security inspections are occurring unless the announcement is related to the legitimate operational functions of the facility and included an updated unannounced security inspection log. The facility submitted a memorandum from the LCDC to the Sheriff which confirms when determining adequate staffing and the need for video monitoring the facility took into consideration 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. The facility submitted a log of unannounced security inspections which confirmed unannounced security inspections are being conducted daily, on every shift, and at irregular times for the purpose of identifying and deterring sexual abuse of detainees. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (b), (c), and (d) of the standard.

§115. 15 - Limits to cross-gender viewing and searches

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

Notes:

(b)(c)(d)(e)(f)(i): LCDC policy SAPPI mandates, "Viewing and Search Requirements for Detainees of the Opposite Gender a) pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances; b) pat-down searches of female detainees by male staff shall not be conducted unless in exigent circumstances; c) all pat-down searches by staff of the opposite gender shall be documented; d) strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner; e) all strip searches and visual body cavity searches shall be documented; g) the facility does 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 medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner; h) all pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner as possible, consistent with security needs and policy, including officer safety." The Auditor reviewed a memorandum from the JA which stated that no cross-gender searches or strip searches were conducted by staff during the audit period. The facility also provided two logs entitled, Cross-Gender Search Log and Strip/Body Cavity Search Log which included entries for date, start time, detainee name and number, the purpose of search and officer name. The logs would be utilized should a cross-gender pat-down search, or strip/body cavity search be conducted. Interviews with three random DOs confirmed cross-gender pat-down searches, strip searches, or visual body cavity searches have not been conducted during the audit period; however, all staff were able to articulate the standard's requirement to document the search. In addition, in interviews with three random DOs it was confirmed staff was knowledgeable in how to conduct a proper pat-down search of a detainee and they would not search a detainee for the sole purpose of determining the detainee's genital characteristics.

(g): LCDC policy SAPPI mandates, "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 bowl 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." The Auditor viewed camera site lines for direct viewing of shower, toilet, and clothing changing areas and confirmed camera angles provided privacy for female detainees using the bathroom or changing; however, the Auditor observed (b) (7)(E) that would enable direct viewing within the (b) (7)(E) of male detainees (b) (7)(E). The shower area was in an enclosed room (b) (7)(E). As there were no detainees housed at LCDC during the

onsite audit the Auditor could not observe cross-gender staff announcements when entering an area that detainees would likely be showering, performing bodily function, or changing clothing.

Does Not Meet (g): The facility is not in compliance with subsection (g) of this standard. While viewing the cameras the Auditor did observe (b) (7)(E) that allowed direct viewing should a male detainee be performing bodily functions. To become compliant the facility must implement a practice that provides privacy for all detainees to perform bodily functions without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine jail checks.

Corrective Action (g): The facility submitted three photographs of the intake cells to include black squares over the (b) (7)(E) areas which confirmed the black squares prevent cross-gender viewing (b) (7)(E) of male detainees performing bodily functions on facility cameras. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (g) of the standard.

§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 serve 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. A review of all submitted LCDC policies confirms that LCDC does not have a policy that mandates the requirements of standard 115.17. The Auditor reviewed the LCSO employment application and confirmed the applicant must sign a statement that information on the application is correct and that any misrepresentation or omission of fact on this or any record submitted pertinent to employment will constitute grounds for refusal to hire or immediate dismissal, regardless of when the false answer or omissions are discovered; however, it does not require the applicant who may have contact with detainees to disclose if he/she had engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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 Auditor reviewed the personnel files of nine facility staff and confirmed background checks were completed prior to employment; however, a file review of a staff member promoted during the audit period, in conjunction with an interview, confirmed he was not asked about previous misconduct prior to receiving his promotion as required by subsection (b) of the standard. In addition, the Auditor was provided with a memorandum that stated, "Staff take annual PREA/SAAPI training that includes the standards requirement to impose upon staff a continuing duty to report sexual misconduct; however, the Auditor was not provided with documentation to confirm that staff had attended the training or acknowledged their duty to do so." In an interview with HR staff, it was confirmed that information would be shared regarding substantiated allegations of sexual abuse with potential employers according to the law. The facility did not maintain contractor files; and therefore, the Auditor could not confirm the one mental health employee contracted through Compass Health received PREA training as required by the standard. Interviews with the AFOD and SDDO indicated there were no recent ICE promotions or hires during the audit period. The Auditor submitted a Background Investigation for Employees and Contractors form to the OPR PSO Unit which included two ICE employees assigned to the facility to verify the completion of the background process. OPR PSO confirmed background investigations and the required five-year investigations were completed for all staff submitted. There are no volunteers at LCDC who provided services to detainees at LCDC during the audit period.

Does Not Meet (a)(b)(c)(d): The facility is not in compliance with subsections (a), (b), (c), and (d) of this standard. The Auditor reviewed the LCSO employment application and confirmed it does not require the applicant who may have contact with detainees to disclose if he/she had engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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 Auditor interviewed and reviewed the personnel file of a facility staff member promoted during the audit period and confirmed they were not asked about previous misconduct as required by subsection (b) of the standard. The facility did not provide documentation that staff members have received

training that includes their continuing duty to report sexual misconduct or acknowledged their duty to do so. The facility did not provide the Auditor with any files of contract staff who may have contact with detainees. To become compliant, the facility must implement a practice that requires the facility not hire, promote, or use the services of any individual, including staff and contractors who have engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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. In addition, the facility must implement a practice that requires staff being considered for promotion be asked in written application, or interview, about previous sexual misconduct and to require that all staff have a continuing affirmative duty to report any misconduct involving sexual abuse. The facility must provide the Auditor with the file of the mental health employee contracted through Compass Health to confirm the contractor did not engage in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community or attempted 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 been civilly or administratively adjudicated to have engaged in such activity prior to providing services to the detainee population. Once implemented the facility must train all applicable staff on the new procedures. The facility must provide the Auditor with 10 personnel files to confirm compliance with subsections (a) and (b) of the standard. If applicable, the facility must provide the Auditor with the personnel files of any staff member, including ICE, who receive a promotion during the CAP period.

Corrective Action (a)(b)(c)(d): The facility submitted an updated copy of the Hiring and Selection Procedure Policy which confirms the facility will require an employee applicant to disclose any previous arrests or convictions and conduct a background check on all new hires and perspective contract employees. The facility submitted updated applications for employment and volunteer status which confirm they require the applicant to disclose if they have 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. However, a review of both applications confirmed they did not include contractors. The facility submitted an email with read receipts to all staff directing staff to not hire, promote, or use the services of any individual, including staff and contractors who have engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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 email further required all staff sign a PREA misconduct disclosure and staff up for promotion be asked about previous sexual misconduct. In addition, the email notified all staff of their continuing affirmative duty to report any misconduct involving sexual abuse. The facility submitted a PREA misconduct disclosure for the mental health employee contracted through Compass Health. The facility submitted six personnel files; however, the Auditor reviewed the submitted files and confirmed although a background check had been conducted on all applicants, the files did not include the updated application or the PREA Misconduct Disclosure; and therefore, the Auditor could not confirm the updated practices to not hire, promote, or use the services of any individual, including staff and contractors who have engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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 and all staff have a continuing affirmative duty to report any misconduct involving sexual abuse had been implemented. The facility submitted a memorandum to Auditor which confirmed there have not been any facility or ICE staff promotions during the CAP period. Upon review of all submitted documentation; or lack thereof, the Auditor now finds the facility in compliance with subsections (c) and (d) or the standard; however, continues to find the facility does not meet subsections (a) and (b).

§115. 21 - Evidence protocols and forensic medical examinations

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

Notes:

(a)(b)(c)(d)(e): The Agency's policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI), 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." LCDC SAPPI further mandates, "When evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination by a Sexual Assault Forensic 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. In the event the investigation is being conducted by a non-federal investigating agency, the facility shall request that the investigating agency follow the applicable requirements of this policy, including requirements related to evidence preservation and forensic examinations." LCDC policy SAAPI states, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse and assault perpetrators to most appropriately address victims' needs." LCDC policy SAAPI further states, "Where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), where practicable. If SAFEs or SANEs cannot be made available, the forensic medical examination can be performed by other qualified health care personnel." In addition, LCDC policy SAAPI states, "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." Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource for crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide services following an incident of sexual abuse. During the onsite audit, the mental health professional from Compass Health came to the facility; however, excited before the Auditor could conduct an interview. The Auditor attempted to contact the mental health professional from Compass Health via telephone; however, calls have not been returned. The Auditor contacted an emergency nurse from Lincoln Mercy Hospital and was able to confirm a SANE is available to provide forensic medical examinations as needed. In addition, the emergency nurse was able to confirm that a victim's advocate would be made available during a forensic exam; however, the nurse could not confirm the advocate would be available during investigatory interviews. In an interview with the facility nurse it was confirmed a SANE would be made available at no cost to the detainee. In the interview with the JA, it was confirmed that the Lincoln County Sheriff's Office (LCSO) is responsible for conducting administrative and criminal sexual abuse investigations. The JA further advised if during the investigation it is determined the reported allegation is criminal in nature, it would be referred to the LCSO. In addition, the JA confirmed both entities are part of the same agency; and therefore, are required to follow the requirements of subsection (a) of the standard. The JA further confirmed should there be a conflict of interest with involved parties the Missouri State Police (MSP) would investigate the incident. In an interview with the PSA Compliance Manager, it was indicated LCDC would request the MSP follow the requirements of subsections (a) through (d) of the standard; however, the facility did not submit documentation to confirm the facility did so. In an interview with the SDDO it was confirmed LCDC policy SAAPI was established in consultation with DHS. There were no allegations of sexual abuse reported at LCDC during the audit period.

Does Not Meet (b)(d)(e): The facility is not in compliance with subsections (b), (d), and (e) of this standard. Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource for crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide services following an incident of sexual abuse. The Auditor contacted an emergency nurse from Lincoln Mercy Hospital and was able to confirm that a victim's advocate would be made available during a forensic exam; however, the nurse could not confirm the advocate would be available during investigatory interviews. In an interview with the PSA Compliance Manager, it was indicated LCDC would request the MSP follow the requirements of subsections (a) through (d) of the standard; however, the facility did not submit documentation to confirm the facility did so. To become compliant, the facility must coordinate with a community resource to provide advocacy services to the detainee victim during the investigation process. The facility must provide documented training of all applicable staff regarding staff responsibility to provide the detainee victim with all requirements of the standard. In addition, the facility must provide documentation that the facility requested the MSP to follow paragraphs (a) through (d) of the standard. If applicable, the facility must provide the Auditor with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (b) and (d) of the standard.

Corrective Action (b)(d)(e): The facility submitted photographs of the "Know Your Rights" poster with a telephone number to the National Sexual Assault Hotline posted in the facility. The Auditor reviewed the poster and confirmed the organization would provide advocacy services to the detainee victim during the investigation process. The facility provided a memorandum to Auditor which confirms there has not been any instances of a detainee victim transported to an outside hospital following an incident of sexual abuse. The facility did not submit documentation to confirm all applicable staff have been trained on the staff responsibility to provide the detainee victim with all requirements of the standard; however, the Auditor accepts facility staff are aware of the standard's requirements through training which required a review of updated Lincoln policy, SAAPI. The facility submitted an email to the MSP which confirms it has requested the MSP to follow the requirements of subsections (a) through (d) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (b), (d), and (e) of the standard.

§115. 22 - Policies to ensure investigation of allegations and appropriate agency oversight
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(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)." LCDC policy SAAPI mandates, "The facility to establish a protocol, to ensure each allegation of sexual abuse is investigated by facility or referred to an appropriate investigative authority. This protocol shall be posted on the facility website, or otherwise made available to the public." LCDC policy SAPPI further mandates, "The facility coordinates with ICE/ERO and other appropriate investigative entities to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse." LCDC policy SAAPI further states, "Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years" and "coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." In addition, LCDC policy SAAPI states, "If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the facility administrator notifies the local government entity or contractor that operates the facility and ICE/ERO. The same notifications are made if a detainee, prisoner, inmate, or resident of the facility is the alleged perpetrator of the sexual abuse" and "the facility administrator promptly reports the incident to the ICE/ERO FOD and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. The facility may separately, and in addition to the required reports and referrals, conduct its own investigation." A review of LCDC policy SAAPI confirms the established protocol does not include notifying the Joint Intake Center (JIC), ICE OPR or the DHS OIG. In addition, the established protocol does not include a description of responsibilities of the Agency, facility, and other investigative entity. Interviews with the JA, PSA Compliance Manager, and Investigator indicated that all allegations of sexual abuse would be referred for investigation and that such records will be maintained in hard copy and electronic format indefinitely. Interviews further indicated when a detainee, prisoner, inmate, or resident of the facility where the detainee victim is a housed is alleged to be the perpetrator of detainee sexual abuse or staff member, contractor or volunteer is the perpetrator of detainee sexual abuse, the facility will notify the appropriate ICE FOD and appropriate investigative authority. In an interview with the SDDO it was confirmed he would be notified immediately and would immediately notify the AFOD, who in turn would notify the JIC and ICE OPR or DHS OIG. The Auditor reviewed the facility's website, https://lcsomo.gov/jaildivision/ and the Agency website, www.ice.gov and confirmed that the Agency website includes the Agency investigative protocol; however, the facility website does not include the required facility investigative protocol.

Does Not Meet (a)(b)(c)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (c), (d), (e), and (f) of the standard. A review of LCDC policy SAAPI confirms it does not contain the requirement 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 JIC, the ICE OPR or DHS OIG. In addition, a review of LCDC policy SAAPI further confirms it does not contain the requirement 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 incident is promptly report to the JIC, the ICE OPR or DHS OIG. A review of LCDC policy SAAPI further confirms it does not include a description of responsibilities of the Agency, facility, and other investigative entity; and therefore, although the facility has established a protocol it does not contain all required elements of the standard. The Auditor reviewed the facility website https://lcsomo.gov/jaildivision/ and confirmed LCDC policy SAAPI is not posted as required by subsection (c) of the standard. To become compliant the facility must update LCDC policy SAAPI to include the requirements 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 JIC, the ICE OPR or DHS OIG, and 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 incident is promptly report to the JIC, the ICE OPR or DHS OIG. In addition, the facility must update LCDC policy SAAPI to include a description of responsibilities of the Agency, facility, and other investigative entity. Once updated, the facility must train all applicable staff on the updated LCDC policy SAAPI and include the policy on the facility website https://lcsomo.gov/jaildivision/.

Corrective Action (a)(b)(c)(d)(e)(f): The facility submitted updated LCDC policy, SAAPI. The Auditor reviewed updated LCDC policy, SAAPI, and confirmed updated LCDC policy, SAAPI requires 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 JIC, the ICE OPR or DHS OIG, and 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 incident is promptly report to the JIC, the ICE OPR or

DHS OIG. A review of updated LCDC policy, SAAPI, further confirms updated LCDC policy, SAAPI, includes a description of responsibilities of the Agency, facility, and other investigative entities. The facility submitted an email with read receipts and an attachment to include updated LCDC policy, SAAPI, which confirmed facility staff have received training on LCDC updated policy, SAAPI. The Auditor reviewed the facility website https://lcsomo.gov/jaildivision/ and confirmed updated LCDC policy, SAAPI, is posted. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), (c), (d), (e), and (f) of the standard.

§115. 31 - Staff training

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

Notes:

(a)(b)(c): The Agency's policy 11062.5.2 mandates, "The Agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed training." LCDC policy SAAPI mandates, "Training on the facility's Sexual Abuse and Assault Prevention and Intervention Program shall be included in initial training for all employees and shall also be included in the annual refresher training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under this standard and shall include: a) the facility's zero-tolerance policies for all forms of sexual abuse; b) definitions and examples of prohibited and illegal sexual behavior; c) the right of detainees and staff to be free from sexual abuse, and from retaliation from reporting sexual abuse; d) instruction that sexual abuse and/or is never an acceptable consequence of detention; e) recognition of situations where sexual abuse and/or sexual assault may occur; f) how to avoid inappropriate relationships with detainees; g) working with vulnerable populations and addressing their potential vulnerability in the general population; h) recognition of the physical, behavioral, and emotional signs of sexual abuse and/or sexual assault and ways to prevent and respond to such occurrences; i) 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; j) the investigation process and how to ensure that evidence is not destroyed; k) prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; l) how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; m) instructions on reporting knowledge or suspicion of sexual abuse and/or assault; and n) instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault." LCDC policy SAPPI further mandates, "The facility shall maintain documentation verifying employee, volunteer and contractor training." In an interview with the TO it was confirmed staff training is conducted through a NIC course entitled "PREA: Your Role in Responding to Sexual Abuse." The Auditor is familiar with the training and can confirm it meets the requirements under subsection (a) of the standard. During the onsite audit, the Auditor conducted a review of nine staff training files and confirmed staff have received the required two-year refresher training; however, the Auditor was not provided with documentation that confirms a mental health employee contracted through Compass Health has completed the required training. In interviews with the AFOD and SDDO, it was indicated ICE staff training is completed yearly and historical records were located within PALMS; however, ICE training records were not provided.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. In interviews with the AFOD and SDDO it was indicated ICE staff training is completed yearly and historical records are located within PALMS; however, ICE training records were not provided. In addition, the Auditor was not provided with documentation that confirms a mental health employee contracted through Compass Health has completed the required training. To become compliant the Agency must provide documentation that all ICE employees who have contact with detainees at LCDC have received documented PREA training as required by subsections (a), (b), and (c) of the standard. In addition, the facility must provide the Auditor with documentation that the mental health employee contracted through Compass Health has completed the training required under subsection (a) of this standard.

Corrective Action (a)(b)(c): The facility submitted training certificates which confirmed the mental health employee contracted through Compass Health and ICE staff assigned to LCDC have completed training as required by subsection (a) of the standard. Upon review of all submitted documentation, the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

§115. 32 - Other training

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

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "All volunteers and other contractors who have contact with detainees shall be 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 ICE/ERO and 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. The facility will maintain documentation verifying employee, volunteer, and contractor training." In an interview with the JA, it was confirmed training is not completed for other contractors who enter the facility. There were no volunteers who provided services to detainees during the audit period.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. In an interview with the JA, it was confirmed that training is not completed for other contractors who enter the facility. To become compliant, the facility must submit to the Auditor documentation that all other contractors at LCDC who have contact with detainees have been trained on their responsibilities under the Agency's and facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training shall be based on the services provided, but at minimum, other contractors should be notified of the Agency's and the facility's zero-tolerance policies regarding sexual abuse and informed how to report such incidents.

Corrective Action (a)(b)(c): The facility submitted training records which confirmed three contractor maintenance staff and one mental health contractor have been trained on their responsibilities under the Agency's and facility's sexual abuse prevention, detection, intervention and response policies and procedures to include being notified of ICE/ERO and the facility's zero-tolerance policy and informed how to report such incidents. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

§115. 33 - Detainee education
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d)(e)(f): LCDC policy SAAPI mandates, "Upon admission Lincoln County Detention Center, all detainees shall be notified of the facility's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee handbook and provided with information about the facility's SAAPI Program. Such information shall include, at a minimum: a) the facility's zero tolerance policy for all forms of sexual abuse or assault; b) the name of the facility PSA compliance manger, and information about how to contact him/her; c) prevention and intervention strategies; d) definitions and examples of detainee-on-detainee sexual abuse and assault, staff on-detainee sexual abuse and assault and coercive sexual activity; e) 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 DHS/OIG and the ICE/OPR investigations processes; f) information about self-protection and indicators of sexual abuse and assault; g) prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and h) the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The facility provides the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The facility maintains documentation of detainee participation in the instruction session. The facility posts on all housing unit bulletin boards the following notices: 1) the ICE/ERO prescribed sexual abuse and assault awareness notice; 2) the name of the PSA Compliance Manager; and 3) Information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (incl. toll-free hotline numbers where available). If no such local organizations exist, the facility makes available the same information about national organizations. The information will be provided in English and Spanish and to other segments of the detainee population with limited English proficiency through translations or oral interpretations. The facility makes available and distribute the ICE/ERO-prescribed "Sexual Assault Awareness Information" pamphlet. Information about reporting sexual abuse shall be included in the ICE Detainee Handbook made available to all immigration detainees at the facility." During the onsite audit, the Auditor observed the consulate contact information, the DHS-prescribed sexual assault awareness notice, with facility contact name and number, contact information for the DHS OIG, reporting numbers for the DRIL, I Speak poster, and the DHS SAA Information pamphlet in English and Spanish; however, did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse. The Auditor reviewed the detainee tablets and kiosks located in the holding cells and was able to confirm that detainees receive PREA information, including information on the zero-tolerance policy, telephone numbers for the DRIL line, and information about what to do should a sexual assault occur. The information was available on the tablet in English only and on the kiosks in English and Spanish. The Auditor further confirmed on the first use of the tablet the detainee must read the jail rules and PREA information, and then press a button entitled, "Acknowledge and Understand." If the detainee does not press the button, they will not have access to the tablet. In addition, the Auditor was able to confirm the facility uploaded the DHS-prescribed SAA Information pamphlet and ICE National Detainee Handbook onto the tablets in English and on the kiosks located in each holding cell in English and in Spanish. In an interview with an intake DO it was indicated if the detainee needed to access the ICE National Detainee Handbook and/or the DHS-prescribed SAA Information pamphlet in a language other than English or Spanish, he/she could do so by way of Google Translate. The DO assigned to intake further indicated should a detainee speak a language other than English or Spanish; staff would assist the detainee to access the google translation services on the devices. In an interview with an intake DO it was further indicated; the facility has access to Language Services Section (LSS) for interpreter services if the need arises. In an interview with the JA and an intake DO it was indicated if a detainee had a hearing disability, the Department of Health or one of several Sheriff's Deputies could be contacted who knows sign language. Should a

detainee have a vision disability, the DO articulated that information could be read to them. Should a detainee have an intellectual, psychiatric, speech disability or limited reading skills, the DO indicated multiple ways they could provide PREA information such as, speaking slowly or speaking in vocabulary the detainee could understand. The DO further confirmed that there were a few Spanish speaking DOs that could interpret if needed. The Auditor was provided with the LCDC orientation PowerPoint slides which are located on both devices and confirmed they contain the information required by subsection (a) of the standard; however, a review of the detainee tablet and kiosks could not confirm the detainee participated in an orientation process or was able to access the PREA information in a manner he/she could understand. The Auditor reviewed the ICE National Detainee Handbook and confirmed the handbook includes information about reporting sexual abuse.

Does Not Meet (c)(d): The facility is not in compliance with subsection (c) and (d) of this standard. The Auditor reviewed the detainee tablets and kiosks located in the holding cells and was able to confirm that detainees receive PREA information, including information on the zero-tolerance policy, telephone numbers for the DRIL line, and information about what to do should a sexual assault occur; however, a review of the detainee tablet and kiosks could not confirm the detainee participated in an orientation process or was able to access the PREA information in a manner he/she could understand. During the onsite audit the Auditor did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse. To become compliant, the facility must implement a practice that documents all detainees receive a PREA orientation in a manner that he/she could understand. In addition, the facility must post the name of a local organization that can assist detainee victims of sexual abuse on the housing unit bulletin boards.

Corrective Action (c)(d): The facility submitted a document titled "Detainee education." The Auditor reviewed the "Detainee education" document; however, could not confirm each inmate had acknowledged the PREA information, including information on the zero-tolerance policy, telephone numbers for the DRIL line, and information about what to do should a sexual assault occurs or that the information was provided during the intake process. The facility submitted a copy of the facility kiosk which confirms the information available in the provided detainee handbook is only available in five languages English, Spanish, French, Filipino, and Vietnamese. The facility submitted photographs of the "Know Your Rights" poster with a telephone number to the National Sexual Assault Hotline posted in the facility. The facility submitted a PREA orientation form which confirmed the detainee received the DHS-prescribed SAA Information pamphlet and the ICE National Detainee Handbook in their preferred language; however, the PREA information form does not confirm the detainee received the information included in the facility handbook in a manner all detainees can understand. The facility sent a training email to applicable staff; however, the training email only confirms staff have received training on the standard's requirement to distribute the DHS-described SAA Information pamphlet to the detainee in a manner he/she could understand; and therefore, the Auditor could not confirm staff were trained on the standard's requirement to provide each detainee with all required elements of the orientation process during the intake process. Upon review of all submitted documentation the Auditor now finds the facility meets subsection (d) of the standard; however, continues to not meet subsection (c).

§115. 35 - Specialized training: Medical and mental health care
Outcome: Does not Meet Standard
Notes:

(a): The facility does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners, and therefore, this standard is not applicable.

(b)(c): LCDC policy SAAPI mandates, "Facility medical staff shall be trained in procedures for examining and treating 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 ICE/ERO. Such specialized training shall include detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse and assault, and how and to whom to report allegations or suspicions of sexual abuse or assault. The facility maintains documentation verifying employee, volunteer, and contractor training." The Auditor observed the nurse's PREA transcript onsite and confirmed she has completed the NIC course entitled "PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting." The Auditor is familiar with this curriculum and can confirm that it meets the requirements under subsection (b) of the standard. The Auditor was not provided training documentation to confirm a mental health employee contracted through Compass Health has completed the required training. In an interview with the SDDO it was confirmed the Agency has reviewed and approved LCDC policy SAAPI.

Does Not Meet (b): The facility is not in compliance with subsection (b) of this standard. The facility did not provide documentation to confirm a mental health employee contracted through Compass Health has completed training as required under subsection (b) of the standard. To become compliant, the facility must submit documentation that confirms the mental health employee contracted through Compass Health has completed the training as required under subsection (b) of this standard.

Corrective Action (b): The facility submitted PREA Training for Contractors and Volunteers with a completed training certificate for the mental health employee contracted through Compass Health. The Auditor reviewed the ICE PREA training for

contractors and volunteers and confirmed it includes detecting and assessing signs of sexual abuse and assault and how and to whom to report allegations or suspicions of sexual abuse or assault; however, the training does not include the standard's requirement to receive training on how to preserve physical evidence of sexual abuse and assault. The facility submitted an email with updated PREA policy to the mental health contract staff and an acknowledgement that the staff member can provide all the services requested; however, the Auditor requires the employee contracted through Compass Health receive training on detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse and assault, and how and to whom to report allegations or suspicions of sexual abuse or assault. The facility submitted a certificate of training to confirm the employee contracted through Compass Health has completed the NIC course "PREA: Your role in responding to sexual abuse." The Auditor reviewed the training curriculum for NIC course "PREA: Your role in responding to sexual abuse" and confirmed the curriculum does not include the elements of subsection (b) of the standard; and therefore, the Auditor could not confirm the employee contracted through Compass Health has completed the required training. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (b) of the standard.

§115. 41 - Assessment for risk of victimization and abusiveness

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

Notes:

(a)(b)(c)(d)(e)(f)(g): LCDC policy SAAPI mandates, "All detainees are screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. The facility uses the assessment to inform assignments of detainees to recreation and other activities, and voluntary work. Each new detainee shall be kept separate from the general population until he/she has been 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 considers, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: a) whether the detainee has a mental, physical, or developmental disability; b) the age of the detainee; c) the physical build and appearance of the detainee; d) whether the detainee has previously been incarcerated or detained; e) the nature of the detainee's criminal history; f) whether the detainee has any convictions for sex offenses against an adult or child; g) whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; h) whether the detainee has self-identified as having previously experienced sexual victimization; and i) the detainee's own concerns about his or her physical safety. Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to items a, g, h, or I, above. The initial screening shall consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive. The facility has appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates." LCDC policy SAAPI further mandates, "The facility shall reassess each detainee's risk of abusiveness between 60 and 90 days from the date of the initial assessment, and any other time when warranted based upon the receipt of addition, relevant information, or following an incident of abuse or victimization." The Auditor reviewed the provided Risk Classification Assessment (RCA) completed by ICE and confirmed the RCA screening takes into consideration whether the detainee has a mental, physical or developmental disability, the age of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as a transgender, whether the detainee has self-identified as having previously experienced sexual victimization, prior convictions for violent offenses, a history of prior institutional violence, and the detainee's own concerns about his or her physical safety; however, it does not consider whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. The Auditor was not able to observe the intake process for a detainee; however, in an interview with a DO assigned to intake it was indicated all detainees would be kept separate on benches within the intake area until they are classified. The detainee would then be housed within one of the cells located within the intake area. The DO assigned to intake further indicated the intake process would normally be completed within one hour of the detainee's arrival. In addition, the DO assigned to intake indicated should a detainee identify as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming it would be placed in an "Alerts" section of the system. In an interview with a staff member responsible for inmate/detainee accounts, and a review of her access to the detainee file, it was confirmed although the staff person did not have a need to know the detainee's responses to questions asked pursuit to standard 115.41, she had access to all areas of the system to include the "Alerts" area where sensitive information disclosed by the detainee during the risk screening would be entered. In an interview with intake staff, it was indicated a reassessment would be conducted after a disciplinary sanction; however, the facility would not conduct a reassessment between 60-to-90-days from the initial assessment, after the initial assessment, after an incident of abuse or victimization, or following the receipt of additional information as required by the standard. Intake staff further indicated a detainee would not be disciplined for refusing to answer, or for not disclosing complete information in response to the intake screening.

Does Not Meet (a)(c)(d)(e)(g): The facility is not compliant with subsections (a), (c), (d), (e), and (g) of the standard. The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. In an interview with a staff member responsible for inmate/detainee accounts, and a review of her access to the detainee file, it was confirmed although the staff person did not have a need to know the detainee's responses to questions asked pursuit to standard 115.41, she had access to the "Alerts" area on the computer screen that included the sensitive information disclosed by detainees during the risk screening. In an interview with intake staff, it was indicated a reassessment would not be conducted between 60-to-90-days from the initial assessment, after the initial assessment, after an incident of abuse or victimization, or following the receipt of additional information as required by the standard. To become compliant, the facility must update their current practice of assessing detainees at intake to identify those likely to be sexual aggressors or sexual abuse victims to include whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as gay, lesbian, bisexual, or gender nonconforming and any prior acts of sexual abuse. The facility must implement a practice that requires all detainees be reassessed between 60-to-90-days from the initial assessment, after the initial assessment, after an incident of abuse or victimization, or following the receipt of additional information as required by the standard. In addition, the facility must implement a practice that ensures appropriate controls were placed on the dissemination of the responses to the initial risk assessment. Once implemented the facility must submit documentation that all applicable staff, including intake and classification staff, have received training on the implemented practices. The facility must submit documentation that only staff with a need to know have access to the detainee's responses to questions asked pursuit to standard 115.41. The facility must submit the files of 10 detainees received during the CAP period to confirm the facility has implemented the required practices. If applicable, the facility must provide the Auditor with 10 detainee files that include reassessments of detainee's risk of victimization and abusiveness, between 60-and-90-days of the initial assessment. In addition, the facility must provide the Auditor with all sexual abuse allegation investigation files that occurred during the CAP period to confirm the detainee victim was reassessed for risk of sexual victimization after an incident of sexual abuse.

Corrective Action (a)(c)(d)(e)(g): The facility submitted updated LCDC policy, SAAPI, which confirms updated LCDC policy, SAAPI, requires facility staff to consider whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as gay, lesbian, bisexual, or gender nonconforming and any prior acts of sexual abuse to identify detainees likely to be sexual abusers or sexual abuse victims to identify detainees who are vulnerable to sexual abuse or sexual aggression. A review of updated LCDC policy, SAAPI, further confirms updated LCDC policy, SAAPI, requires all detainees to be reassessed between 60-to-90-days from the initial assessment, after an incident of sexual abuse or victimization, and following the receipt of additional information as required by the standard. The facility submitted an updated "PREA/SAAPI Victimization" risk assessment which confirms the initial risk assessment includes all elements required by subsections (c) and (d) of the standard. The facility submitted a screenshot of an alert screen which confirms the facility has implemented appropriate controls as to what users have access to the information provided on the alert screen. The facility submitted an email sent to staff with the attached PREA/SAAPI Victimization risk assessment and read receipts which confirmed staff have been trained on the standard's requirement to consider prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence or sexual abuse. The facility did not provide 10 detainee files to confirm the facility implemented the updated practice to assess detainees at intake to identify those likely to be sexual aggressors or sexual abuse victims to include whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as gay, lesbian, bisexual, or gender nonconforming and any prior acts of sexual abuse; however, the Auditor accepts the practice was implemented recently not allowing for the required file documentation to be available. The facility submitted a memorandum to Auditor which confirms there have not been any detainees held longer that 60 days requiring a reassessment or any allegations of sexual abuse during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (c), (d), (e), and (g) of the standard.

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

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "All detainees are screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. The facility uses the assessment to inform assignment of detainees to recreation and other activities, and voluntary work." LCDC policy SAAPI further mandates, "When making assessment and housing decisions for a transgender or intersex detainee, the facility considers the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility does 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 a year to review any threats to safety experienced by the detainee. When operationally feasible transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening takes into consideration whether the detainee has a mental, physical or developmental disability, the age of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as a transgender, whether the detainee has self-identified as having previously experienced sexual victimization, prior convictions for violent offenses, a history of prior institutional violence, and the detainee's own concerns about his or her physical safety; however, it does not consider whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. In an interview with the nurse, it was indicated intake does not consult with medical prior to making housing decisions for a transgender or intersex detainee. In addition, the nurse indicated that the facility does not conduct a reassessment of a transgender or intersex detainee's placement twice a year to review any threats to his/her safety. Interviews with intake staff confirmed that housing decisions would be made based on security and not a detainee's gender self-identification or an assessment of the effects of placement on the detainee's health and safety. Interviews with the PSA Compliance Manager and three random DOs confirmed a transgender or intersex detainee would be able to shower separately. Interviews with the JA and PSA Compliance Manager confirmed that a transgender or intersex detainee has not been housed at the facility during the audit period.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. Therefore, the facility does not have a viable risk assessment as required under standard 115.41 and subsequently will not be compliant with subsection (a) of this standard. In an interview with the nurse, it was indicated intake does not consult with medical prior to making housing decisions for a transgender or intersex detainee. In addition, the nurse indicated that the facility does not conduct a reassessment of the transgender or intersex detainee's placement to review any threats to his/her safety. Interviews with intake staff confirmed that housing decisions would be made based on security and not a detainee's gender self-identification or an assessment of the effects of placement on the detainee's health and safety. To become compliant the facility must update their current practice of assessing detainees at intake to identify those likely to be sexual aggressors or sexual abuse victims to include whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as gay, lesbian, bisexual, or gender nonconforming and any prior acts of sexual abuse. In addition, the facility must implement a practice that requires in making assessment and housing assignments for transgender and intersex detainees the facility considers the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety and based on security classification only. The facility must implement a practice that includes consulting with medical and mental health professionals as soon as practicable when a transgender or intersex detainee is assigned to their initial housing. In addition, the facility must implement a practice that includes conducting a reassessment of a transgender or intersex detainee's placement twice a year to review any threats to his/her safety. Once implemented the facility must submit documentation that all intake, classification, medical, and mental health staff, have received training on the new procedure. The facility must submit files of 10 detainees received during the CAP period. If applicable the facility must submit to the Auditor any transgender or intersex detainee who arrives at LCDC during the CAP period.

Corrective Action (a)(b): The facility submitted updated LCDC policy, SAAPI, which confirms updated LCDC policy, SAAPI, requires when making assessment and housing decisions for a transgender or intersex detainee the facility considers the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. A review of updated LCDC policy, SAAPI, further confirms updated LCDC policy, SAAPI, requires the facility consults with a medical or mental health professional as soon as practicable when making assessments and housing determinations for transgender or intersex detainees, the facility will not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee, and the facility will take into consideration a detainee's self-identification of his/her gender and self-assessment of safety needs. In addition, a review of updated LCDC policy, SAAPI, confirms updated LCDC policy, SAAPI, requires 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 a year to review any threats to safety experienced by the detainee. The facility submitted a PREA/SAAPI Victimization form which confirms the initial risk assessment includes all elements required by subsections (c) and (d) of the standard. The facility submitted an email sent to staff with read receipts and an attached PREA/SAAPI Victimization risk assessment which confirms all applicable staff have been trained on the standard's requirement to consider prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence or sexual abuse; however, a review

of the email confirms the facility did not train all intake, classification, medical, and mental health staff on the standard's requirements to conduct a reassessment of a transgender or intersex detainee's placement twice a year to review any threats to his/her safety or in making assessment and housing assignments for transgender and intersex detainees the facility considers the detainee's gender self-identification. The facility submitted 10 detainee files utilizing the PREA/SAAPI Victimization risk assessment form; however, the files submitted did not include the updated form which includes whether the detainee has any prior acts of sexual abuse. The facility did not submit any detainee files to confirm information gained from the initial risk assessment is considered when determining recreation and other activities and voluntary programming. The facility submitted a memorandum to Auditor which confirms there have been no transgender or intersex detainees housed at LCDC during the CAP period. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsections (a) and (b) of the standard.

§115. 43 - Protective custody
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d)(e): LCDC policy 3.15.1, SMU Procedures/Housing Standards states, "A detainee considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director to determine if ICE can provide additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days." LCDC policy 3.15.1 further states, "Detainees in SMU shall have access to programs and services such as commissary, library, religious guidance and recreation." A review of LCDC policy 3.15.1 confirms the facility does not have written procedures that require the facility: 1) clearly document the basis for the facility's concern for the detainee's safety; and the reasons why no alternative means of separation can be arranged; 2) require a supervisory staff member conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter; and 3) notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. The Auditor reviewed a memorandum that reviews would be conducted within 72 hours of placement, every 7 days for the first month and then, if necessary, every 10 days thereafter and that the facility would notify ICE within 72 hours by email should a detainee be placed in protective custody or administrative segregation. In an interview with the JA, it was indicated notifications would be made to ICE immediately and proper reviews would be conducted at the appropriate times and documented. There were no allegations of sexual abuse reported during the audit period. In an interview with the JA, it could not be confirmed that LCDC policy 3.15.1 was developed in consultation with the ICE/ERO FOD having jurisdiction over the facility.

Does Not Meet (a)(d)(e): The facility is not in compliance with subsections (a), (d), and (e) of the standard. A review of LCDC policy 3.15.1 confirms the facility does not have written procedures that require the facility: 1) clearly document the basis for the facility's concern for the detainee's safety; and the reasons why no alternative means of separation can be arranged, require a supervisory staff member to conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter; and 3) notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. In an interview with the JA, the Auditor could not confirm LCDC policy 3.15.1 was developed in consultation with the ICE/ERO FOD having jurisdiction over the facility. To become compliant the facility must updated LCDC 3.15.1, in consultation with the ICE/ERO FOD having jurisdiction over the facility, to include the facility will clearly document the basis for the facility's concern for the detainee's safety; and the reasons why no alternative means of separation can be arranged, a supervisory staff member shall conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter, and the facility shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. Once updated the facility must train all security staff on the updated LCDC policy 3.15.1. If applicable, the facility must submit to the Auditor the files of any detainees placed in protective custody due to being vulnerable to sexual abuse or assault during the CAP period.

Corrective Action (a)(d)(e): The facility submitted updated LCDC policy, SAAPI, which confirms it requires a supervisory staff member to conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter. A review of updated LCDC policy, SAAPI, further confirms updated policy, SAAPI, requires the facility to notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. The facility submitted updated policy, SMU Procedures Housing Standards, which confirms updated policy, SMU Procedures Housing Standards, requires staff document the

basis for the facility's concern for the detainee's safety; and the reasons why no alternative means of separation can be arranged. The facility submitted emails with read receipts which confirmed all applicable staff have been trained on updated LCDC policies SAAPI and SMU Procedures Housing Standards. The facility submitted an email which confirms updated policies SAAPI and SMU Procedures Housing Standards were developed in consultation with the ICE FOD. The facility submitted a memorandum to Auditor which confirms there have been no detainees placed in protective custody due to being vulnerable to sexual abuse or assault during the CAP period. Upon review of all applicable documentation the Auditor now finds the facility in substantial compliance with subsections (a), (d), and (e) of the standard.

§115. 51 - Detainee reporting
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "Detainees shall have multiple ways to privately and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting," and "staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." LCDC policy SAPPI further mandates, "Detainee reports of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents may be made using any available methods of communication, including but not limited to: 1) verbal reports to any staff member (including the PSA Compliance Manager or medical staff); 2) written informal or formal requests of grievances to the facility; 3) sick call requests; 4) reports to an individual or organization outside the facility (family members, friends, or other outside entities) who can contact facility staff; 5) written informal or formal requests or grievances (including emergency grievances) to the ICE/ERO; 6) telephone calls or written reports to the DHS/OIG, ICE/OPR, or ICE/DRIL; and 7) telephone calls or written reports to consular officials." During the onsite audit the Auditor observed within each holding cell the PREA audit notice, DHS-prescribed sexual assault awareness notice, with the facility PSA Compliance Manager's name and number, reporting numbers for the DRIL, contact information for the DHS OIG, I Speak poster, and the DHS SAA Information pamphlet in English and Spanish. The Auditor also observed consulate contact numbers scrolling on the kiosk system located within each cell. The ICE Detainee Handbook with reporting numbers can be accessed on the kiosk and translated utilizing Google Translate in over 100 languages. The Auditor also reviewed the orientation PowerPoint located on the kiosk and confirmed it includes several resources on how a detainee could report retaliation or staff neglect or violations that may have contributed to such incidents and specific instruction on avenues to report anonymously and can be translated into the detainee's preferred language utilizing Google Translate. During the onsite audit, the Auditor attempted to place calls to the DHS OIG and to the ICE DRIL posted telephone numbers. The Auditor was unable to complete the calls as the line would disconnect. Interviews with three random DOs confirmed they would accept reports made verbally, in writing, anonymously and from third parties and they would promptly document any verbal reports.

Does Not Meet (a): The facility is not in compliance with subsections (a) of this standard. The Auditor attempted to call the DHS OIG and ICE DRIL posted telephone numbers; however, the line would disconnect. To become compliant, the facility must submit documentation that confirms each number provided to the detainees for reporting sexual abuse is in good working order.

Corrective Action (a): The facility submitted a memo confirming staff have been able to conduct calls to the DHS OIG and the DRIL from several locations within the facility to include the Booking Holding Cell. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 53 - Detainee access to outside confidential support services
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigations and the prosecution of sexual abuse and assault perpetrators to most appropriately address their needs. The facility has entered into memoranda of understanding or other agreement with community service providers or, if local providers are not available, national organization that provide legal advocacy and confidential emotional support services for immigrant victims of crime. The facility administrator has established procedures to make available to detainees' information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If no such local organization exist, the facility makes available the same information about national organizations. Following an allegation of sexual abuse, the facility administrator has established procedures to make available, to the full extent possible, additional outside victim services. The facility does attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available, the facility works with ICE/ERO to provide these services from a qualified staff member from a community-based organization, or a qualified staff member. The victim advocate shall be able to provide emotional support, crisis intervention, information, and referrals. The facility enables reasonable communication between detainees and these organizations or agencies, in as confidential a manner as possible. Staff shall 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." Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource as crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide valuable expertise and support during an investigation and the prosecution of sexual abuse and assault perpetrators. In addition, interviews could not confirm that Compass Health would provide legal advocacy and confidential emotional support services for immigrant victims of crime. During the onsite audit, the mental health professional from Compass Health came to the facility; however, excited before the Auditor could conduct an interview. The Auditor attempted to contact the mental health professional from Compass Health via telephone; however, calls have not been returned. During the onsite audit the Auditor did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse or a disclaimer that informed detainees prior to access with a local organization 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.

Does Not Meet (a)(c)(d): The facility is not in compliance with subsections (a), (c) and (d) of this standard. Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource as crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide valuable expertise and support during an investigation and the prosecution of sexual abuse and assault perpetrators. In addition, interviews could not confirm that Compass Health would provide legal advocacy and confidential emotional support services for immigrant victims of crime. During the onsite audit, the mental health professional from Compass Health came to the facility; however, excited before the Auditor could conduct an interview. In addition, the Auditor did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse or a disclaimer that informed detainees prior to access with a local organization 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. In an interview with the PSA Compliance Manager, it could not be confirmed the facility has attempted to enter an MOU with a community resource to provide support in the areas of crisis intervention, counseling, investigation, and prosecution of sexual abuse perpetrators to address victims' needs most appropriately. To become compliant, the facility must submit documentation to confirm LCDC has attempted to enter into an MOU with an outside community service provider, or national organization, to provide valuable expertise and support during an investigation and the prosecution of sexual abuse and assault perpetrators and legal advocacy and confidential emotional support services for immigrant victims of crime. In addition, the facility must make available to all detainees the contact information to a local entity, or national organization, that can provide legal advocacy and confidential emotional support services for detainee victims of sexual abuse and must inform detainees in a manner all detainees can understand, prior to giving them access to any outside resource, the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Corrective Action (a)(c)(d): The facility submitted an email confirming it has attempted to enter into an agreement with Turning Point Advocacy Services. The facility submitted a posted "Know Your Rights" poster which confirms the organization will provide valuable expertise and support during an investigation and the prosecution of sexual abuse and assault perpetrators and legal advocacy and confidential emotional support services for immigrant victims of crime; however, the poster only includes a contact telephone number; and therefore, the Auditor could not confirm the facility provides detainees with the organization's mailing address as required by subsection (c) of the standard. In addition, the facility did not provide documentation to confirm prior to giving detainees access to any outside resource, the facility will notify the detainee the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard; however, continues to find the facility does not meet subsections (c) and (d).

§115. 65 - Coordinated response

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

Notes:

(a)(b)(c)(d): LCDC policy, SAAPI, mandates, "The facility must use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which 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." LCDC policy, SAPPI, further mandates, "If a victim is transferred between detention facilities, the sending facility, as permitted by law, informs the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility). If the receiving facility is unknown to the sending facility, the sending facility notifies the ICE/ERO, so he or she can notify the receiving facility. Where an alleged victim of sexual abuse or assault that occurred elsewhere in ICE/ERO custody is subsequently transferred to the detention facility, the facility complies with all responses and intervention requirements outlined by this policy, as appropriate based on the nature and status of the case. If any of these requirements cannot be met, the facility will consult with the ICE Field Office Director to determine if ICE/ERO can provide additional assistance." A review of

LCDC policy, SAAPI, also serving as the facility coordinated response plan, confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership. In addition, a review of LCDC policy SAAPI confirms it states, "if a victim is transferred between detention facilities, the sending facility, as permitted by law, informs the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility)" the standard requires if a victim is transferred to a facility covered by subparts (a) and (b) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services unless the victim requests otherwise. In an interview with the JA it was confirmed should a detainee be transferred to a DHS facility the PSA Compliance Manager would inform the receiving facility of the incident and victim's potential need for medical or social services and should a detainee be transferred to a non-DHS facility the facility would inform the receiving facility of the incident and the victim's potential need for medical or social services, as permitted by law, and only at the request of the detainee, however, the standard requires if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services unless the victim requests otherwise.

Does Not Meet (a)(c)(d): The facility is not in compliance with subsections (a), (c), and (d) of the standard. A review of LCDC policy SAAPI, also serving as the facility coordinated response plan, confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership. In addition, a review of LCDC policy SAAPI confirms it states, "if a victim is transferred between detention facilities, the sending facility, as permitted by law, informs the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility)" the standard requires if a victim is transferred to a facility covered by subparts (a) and (b) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services unless the victim requests otherwise. To become compliant, the facility must update LCDC policy SAAPI to include the coordinated actions to be taken staff first responders, medical and mental health practitioners, investigators, and facility leadership. In addition, the facility must updated LCDC policy SAAPI to include the verbiage "if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the 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 and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise." Once updated the facility must submit documentation that confirms all applicable staff, including medical personnel, have been trained on the requirement of subsection (d) of the standard that states, "If a victim of sexual abuse is transferred to a non-DHS Facility not covered by paragraph (c) of the 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 provide the Auditor with any sexual abuse investigation files, and corresponding medical and mental health records, of a detainee who was transferred due to an incident of sexual abuse to a facility not covered by paragraph (c) of the standard to confirm compliance with subsection (d) of the standard.

Corrective Action (a)(c)(d): The facility submitted updated LCDC policy, SAAPI, which confirms updated LCDC policy, SAAPI, includes the coordinated actions to be taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership. A review of updated LCDC policy, SAAPI, further confirms updated LCDC policy, SAAPI, includes the standard's requirements "If a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the 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 and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise." The facility submitted a memorandum to Auditor which confirms there have not been any detainees who have been transferred due to an incident of sexual abuse to a facility not covered by paragraph (c) during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (c), and (d) of the standard.

§115. 67 - Agency protection against retaliation

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

Notes:

(a)(b)(c): LCDC policy SAPPI mandates, "Staff, contractors, and volunteers 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. The facility employs 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 or assault, the facility, in concert with ICE/ERO, monitors to see if there are facts that may suggest possible retaliation by detainees or staff, and facility monitors 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 by staff. The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The Auditor reviewed the Sexual Assault Evaluation form and confirmed it requires that the detainee is reviewed after 30-60-90-days and not beginning at the time the allegation is made. Interviews with the JA and PSA Compliance Manager confirmed that the facility does not monitor staff for retaliation following an incident of sexual abuse.

Does Not Meet (b)(c): The facility is not in compliance with subsection (b) and (c) of this standard. The Auditor reviewed the Sexual Assault Status Evaluation form and confirmed it includes 30-60-90-day assessment blocks and does not require monitoring to begin immediately following a report of sexual abuse. In addition, in interviews with the JA and PSA Compliance Manager it was confirmed monitoring following a report of sexual abuse does not include staff members. To become compliant, the facility must implement a practice that requires monitoring of retaliation to begin immediately following a report of sexual abuse and not 30 days after the report is made. In addition, the facility must implement a practice that includes monitoring of staff involved in making the report. The facility must train all applicable staff involved in the monitoring of detainee victims of sexual abuse in the new practice and document such training. The facility must also provide the Auditor with copies of all sexual abuse allegation investigation files and corresponding monitoring documentation that occur during the CAP period to confirm compliance with the standard.

Corrective Action (b)(c): The facility submitted a blank Sexual Assault Status Evaluation form which confirmed the Sexual Assault Status Evaluation form includes an initial monitoring date starting immediately after the allegation of sexual abuse is reported. The facility submitted an email with read receipts to include the Sexual Assault Status Evaluation form which confirmed all applicable staff involved in the monitoring of detainee victims of sexual abuse have been trained on the updated practice. The facility submitted a memorandum to Auditor which confirms there has not been any sexual abuse allegations or corresponding monitoring documentation that occurred during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (b) and (c) of the standard.

§115. 68 - Post-allegation protective custody
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "Victims and vulnerable detainees shall be housed in a supportive environment that represents the least restrictive housing option possible (e.g., in a different housing unit, transfer to another facility, medical housing, or protective custody), and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical or mental health needs of the victim. Placement of administrative segregation should be the last resort when no other housing options exist. Victims may not be held for longer than five days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim. The facility notified the appropriate ICE/ERO FOD whenever a detainee victim, or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hours. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault." In interviews with the JA and PSA Compliance Manager it was indicated detainees would be held in administrative segregation for the least amount of time, that placement would not exceed five days except in highly unusable circumstances or at the request of the detainee, and notification would be immediately made to the ICE FOD, via a phone call, should a detainee be held in administrative segregation for 72 hours. In an interview with the PSA Compliance Manager, it was confirmed detainees placed into protective custody after being subjected to sexual abuse would not be reassessed prior to their return to general population to consider any increased vulnerability of the detainee as a result of the sexual abuse. There were no detainees placed in protective custody at LCDC due to an allegation of sexual abuse during the audit period.

Does Not Meet (c): The facility is not in compliance with subsections (c) of the standard. In an interview with the PSA Compliance Manager, it was confirmed detainees placed into protective custody after being subjected to sexual abuse would not be reassessed prior to their return to general population to consider any increased vulnerability of the detainee as a result of the sexual abuse. To become compliant, the facility must develop a practice that includes a proper reassessment of all detainees placed in protective custody after being subjected to sexual abuse prior to release to general population to consider any increased vulnerability of the detainee as a result of the sexual abuse. Once implemented, the facility must submit documented training of all applicable staff on the updated practice. If applicable, the facility must submit any allegation of sexual abuse investigations

that include the detainee being placed in protective custody due to an allegation of sexual abuse, and the corresponding detainee's detention file, that occur during the CAP to confirm the new practice has been implemented.

Corrective Action (c): The facility submitted updated LCDC policy, SAAPI, which confirms updated LCDC policy, SAAPI, requires a detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault. The facility submitted training sign in sheets which confirmed applicable staff have been trained on updated LCDC policy, SAAPI. The facility submitted a memorandum to Auditor which confirms there have not been any detainees placed in protective custody due to an allegation of sexual abuse during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (c) and is now compliant with this standard.

§115. 71 - Criminal and administrative investigations

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

Notes:

(a)(b)(c)(e)(f): LCDC policy SAAPI mandates, "All investigations must be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators. 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 reviews any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. The ICE Office of Professional Responsibility will typically be the appropriate investigative office with DHS, as well as the DHS OIG in cases where the DHS OIG is conducting an investigation. The facility has written procedures for administrative investigations, including provisions requiring: 1) preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; 2) interviewing alleged victims, suspected perpetrators, and witnesses; 3) reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; 4) 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 a detainee who alleged sexual abuse or assault to submit to a polygraph; 5) an effort to determine whether actions or failures to act at the facility contributed to the abuse; 6) 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; 7) retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years; and 8) coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." LCDC policy SAPPI further mandates, "The departure of the alleged abuser or victim from the employment or control of the facility does not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse and assault, the facility does cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Where an alleged victim of sexual abuse or assault that occurred elsewhere in ICE/ERO custody is subsequently transferred to the facility, the does also cooperate with any administrative or criminal investigative efforts arising from the incident. Following an investigation conducted by the facility into a detainee's allegation of sexual abuse, the facility notifies ICE/ERO of the results of the investigation and any responsive actions taken so that the information can be reported to ICE/ERO headquarters and to the detainee." A review of LCDC policy SAAPI confirms the facility shall develop written procedures to include all provisions of subsection (c) of the standard; however, the facility has not submitted to the Auditor the facility's developed written procedures. In an interview with the Investigator, it was confirmed that he would conduct investigations in a prompt, thorough and objective manner. The Auditor was provided with his certificate of completion from the National Institute of Corrections for the course: PREA: Investigating Sexual Abuse in a Confinement Setting. The Auditor reviewed the training curriculum and confirmed it included all elements required by the standard. In interviews with the JA, PSA Compliance Manager, and Investigator it was confirmed an administrative investigation would be completed upon a substantiated finding of sexual abuse resulting from a criminal investigation and if the finding was unsubstantiated, it would be reviewed to ascertain if an administrative investigation was warranted. Interviews with the JA and PSA Compliance Manager confirmed that DHS would be consulted pending an administrative investigation. In interviews with the JA and Investigator, it was confirmed the departure of the alleged victim or perpetrator from the employment or control of the facility or agency would not provide a basis for terminating an investigation. In an interview with the investigator, it was confirmed all criminal investigations would be conducted by the LCSO unless there is a conflict of interest that would require the investigation be referred to the MSP. During the onsite audit, the Auditor interviewed a representative from MSP and confirmed they would investigate the incident per Missouri Statue and the facility would remain informed of the investigations progress through telephone calls or emails. There were no allegations of sexual abuse reported at the facility during the audit period.

Does Not Meet (a)(b)(c)(e)(f): The facility is not in compliance with subsections (a), (b), (c), (e), and (f) of this standard. The facility has not established the required written procedures for conducting administrative investigations. As the facility does not have a written protocol, the requirements of subsections (a), (b), (c), (e), and (f) that must be included in the protocol are

also non-compliant. To become compliant, the facility must develop a written protocol that includes all elements of subsections (a), (b), (c), (e), and (f) of the standard. In addition, the facility must submit document that all applicable staff have been trained on the protocol's content. If applicable, the facility must provide the Auditor with copies of all sexual abuse allegation investigation files that occurred during the CAP period.

Corrective Action (a)(b)(c)(e)(f): The facility submitted a PREA Coordinated Response Plan (timeline chart) which is considered the facility investigative protocol. A review of the submitted PREA Coordinated Response Plan (timeline chart) confirms the updated PREA Coordinated Response Plan (timeline chart) requires the facility access credibility without regard to the individual's status as detainee, staff, or employee and does not require the detainee victim to take a polygraph test. A review of the PREA Coordinated Response Plan (timeline chart) further confirms the PREA Coordinated Response Plan (timeline chart) includes the requirements "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted, upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate" and "administrative investigations will be conducted after consultation with ICE/ERO and the local law enforcement agency." In addition, a review of the PREA Coordinated Response Plan (timeline chart) confirms it requires the facility to coordinate and sequence administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation, to cooperate with the local law enforcement agency and attempt to remain informed about the progress of the investigation when the local law enforcement agency investigates an alleged sexual abuse and assault, and the facility will continue an investigation regardless of whether the alleged abuser or victim has left the employment or control of the facility or Agency. The facility submitted an email with read receipts which confirmed all applicable staff have been trained on the updated investigative protocol. The facility submitted a memorandum to Auditor which confirms there have not been any sexual abuse allegations that occurred during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), (c), (e), and (f) of the standard.

§115. 81 - Medical and mental health assessments; history of sexual abuse

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

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "If screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation, no later than two working days from the date of the assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming; and therefore, the initial risk assessment does not adequately indicate if a detainee has experienced prior sexual victimization or perpetrated sexual abuse. In an interview with the nurse, it was indicated medical evaluations would be completed on the next working day; however, the mental health professional is only at the facility one day a week; and therefore, should a mental health referral be initiated the facility cannot confirm the evaluation would be conducted within 72 hours of the referral as required by the standard.

Does Not Meet (a)(c): The facility is not in compliance with subsection (a) and (c) of this standard. The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming; and therefore, the initial risk assessment does not adequately indicate if a detainee has experienced prior sexual victimization or perpetrated sexual abuse. In addition, in an interview with the nurse it was confirmed the mental health professional is only at the facility one day a week; and therefore, should a mental health referral be initiated the facility cannot confirm the evaluation would be conducted within 72 hours of the referral as required by the standard. To become compliant, the facility must develop and implement a procedure that requires the facility to adequately access all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims. In addition, the facility must implement a practice that requires all detainees referred to mental health be seen within 72 hours as required by subsection (c) of the standard. Once implemented the facility must submit documentation that all applicable staff, including intake, and medical, and mental health have received training on the new procedure. If applicable, the facility must submit to the Auditor all intake, medical, and mental health records of any detainee, who during the CAP period, indicates pursuant to standard §115.41 they have experienced prior sexual victimization or perpetrated sexual abuse.

Corrective Action (a)(c): The facility submitted an updated PREA/SAAPI Victimization risk assessment which confirms the initial risk assessment includes all elements required by subsections (c) and (d) of the standard. The facility submitted an email sent to staff with read receipts to include an attached PREA/SAAPI Victimization risk assessment which confirmed staff have been trained on the standard's requirement to consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior

institutional violence or sexual abuse to determine whether a detainee has experienced sexual abuse or perpetrated sexual abuse. The facility submitted an email thread with the employee contracted through Compass Health which confirms his ability to conduct a mental health evaluation within 72 hours on any detainee who during the initial risk screening identified as experiencing prior sexual victimization or perpetrating sexual abuse. The facility submitted a memorandum to Auditor which confirms there have not been any detainees who were identified during the initial risk assessment to have experienced prior sexual victimization or perpetrated sexual abuse during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (c) of the standard.

§115. 83 - Ongoing medical and mental health care for sexual abuse victims and abusers

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

Notes:

(a)(b)(c)(d)(e)(f)(g): LCDC policy SAAPI mandates, "The facility offers medical and mental health evaluations and, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. The facility attempts 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. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility provides such victims with medical and mental health services consistent with the community level of care." In an interview with the facility nurse, it was indicated detainees victimized by sexual abuse would receive a medical and mental health evaluation and, as appropriate, treatment; however, the nurse could not articulate what treatment would be offered. In addition, the nurse could not confirm that the facility would attempt to conduct a mental health evaluation of all known-detainee-on-detainee abusers. During the onsite audit, the Auditor contacted an emergency room nurse at Lincoln Mercy Hospital and confirmed medical treatment would be provided consistent with the community level of care to include pregnancy tests, timely and comprehensive information about lawful pregnancy related medical services, needed lawful pregnancy related medical services, and tests for sexually transmitted infections without financial cost and regardless of whether the victim names the abuser. However, the emergency nurse could not confirm that the detainee would be offered a mental health evaluation or treatment consistent with community care, if appropriate. There was no allegation of sexual abuse reported at LCDC during the audit period.

Does Not Meet (a)(b)(c)(f)(g): The facility is not in compliance with subsections (a), (b), (c), (f), and (g) of the standard. In an interview with the facility nurse, it was indicated detainees victimized by sexual abuse would receive a medical and mental health evaluation and, as appropriate, treatment; however, the nurse could not articulate what treatment would be offered. In addition, the nurse could not confirm that the facility would attempt to conduct a mental health evaluation of all known-detainee-on-detainee abusers. During the onsite audit the Auditor contacted an emergency room nurse at Lincoln Mercy Hospital and confirmed medical treatment would be provided consistent with the community level of care to include pregnancy tests, timely and comprehensive information about lawful pregnancy related medical services, needed lawful pregnancy related services, and tests for sexually transmitted infections without financial cost and regardless of whether the victim names the abuser. However, the emergency nurse could not confirm that the detainee would be offered a mental health evaluation or treatment consistent with community care, if appropriate. To become compliant the facility must provide documentation that confirms mental health staff are available to provide the detainee victim of sexual abuse with all required elements of subsections (a), (b), (c), (f), and (g) of the standard. If applicable, the facility must provide the Auditor with any sexual abuse allegation investigative files that occurred during the CAP period. If applicable, the facility must provide the detainee files, including medical and mental health, of any known detainee-on-detainee abusers housed at LCDC during the CAP period.

Corrective Action (a)(b)(c)(f)(g): The facility submitted an email thread with the employee contracted through Compass Health which confirms the mental health staff contracted through Compass Health can provide all required elements of subsections (a), (b), (c), (f), and (g) of the standard. The facility submitted a memorandum to Auditor which confirms there have been no sexual abuse allegations or known detainee-on-detainee abusers housed at LCDC during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), (c), (f), and (g) of the standard.

§115. 86 - Sexual abuse incident reviews

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

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "The facility conducts a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For a substantiated or unsubstantiated allegation, the facility prepares 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 and assault. Unfounded allegation means an allegation was investigated and determined not to have occurred. The facility does implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and the response shall be forwarded to ICE/ERO for transmission to the ICE/ERO PSA Coordinator. The facility provides any further information regarding such incident reviews as requested by the ICE/ERO PSA Coordinator. The 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 facility will conduct an annual review of all sexual abuse and assault investigations and resulting incident reviews to assess and improve sexual abuse and assault intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse and assault during the annual reporting period, then the facility will prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and ICE/ERO for transmission to the ICE PSA Coordinator (this notification must be sent directly to the FOD)." In interviews with the JA and PSA Compliance Manager, it was confirmed the facility does not prepare a negative report in the absence of reported allegations during the year. There were no allegations of sexual abuse reported at LCDC during the audit period.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. Interviews with the JA and PSA Compliance Manager, it was confirmed the facility does not prepare a negative report in the absence of reported allegations during the year. To become compliant, the facility must submit documentation to the Auditor that a negative PREA report was completed for the year 2022 and forwarded to the facility administrator, the FOD or designee, and the Agency PSA Coordinator.

Corrective Action (c): The facility submitted an email with a copy of the 2022 negative PREA report attached which confirmed the facility submitted the annual report to the Chicago Field Office and the Facility Administrator. The Auditor confirmed via an email from the Agency PSA Coordinator the facility submitted the facility 2022 Negative report to the Agency PSA Coordinator. Upon review of all available documentation the Auditor now finds 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.

Jodi Upshaw January 8, 2024
Auditor's Signature & Date

(b) (6), (b) (7)(C) January 8, 2024
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) January 10, 2024
Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	4/25/2023	**To:**	4/27/2023
AUDITOR INFORMATION			
Name of auditor:	Jodi Upshaw	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	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 number:**	409-866-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Chicago Field Office
Field Office Director:	Michael A. Melendez
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	101 W. Ida B. Wells Parkway, STE 4000 Chicago, IL 60605
Mailing address: (if different from above)	Same as above

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Lincoln County Detention Center		
Physical address:	65 Business Park Dr., Troy, Missouri 63379		
Mailing address: (if different from above)	Same as above		
Telephone number:	636-528-8564		
Facility type:	IGSA		
PREA Incorporation Date:	April 14, 2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Jail Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	636-528-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	SSGT
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	636-528-

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	01/06/2023
Notes:	

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Lincoln County Detention Center (LCDC) was conducted on April 25, 2023 – April 27, 2023, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Jodi Upshaw employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the U.S. ICE PREA auditing process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. LCDC is a county government facility governed by the Lincoln County Sheriff's Office (LCSO) and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The audit period is from April 14, 2020, through April 27, 2023. This is the first DHS PREA audit for LCDC.

The facility houses adult male and female detainees with low, medium, and high custody levels who are awaiting transportation to an ICE facility. The design capacity for the facility is 224 and includes detainees, County, State and United States Marshals Service (USMS) arrestees. The average daily ICE population for the prior 12 months was 0. The facility reported there were 74 ICE detainees booked into the facility in the last 12 months with an average length of time in custody of 72 hours or less. The current population on the first day of the audit was zero. According to the Jail Administrator (JA) detainees are housed solely within initial intake area cells, the intake holding cells, or medical cells just off the intake area.

Approximately two weeks prior to the audit, the ERAU Team Lead (TL), (b) (6), (b) (7)(C), provided the Auditor with facility policies and other pertinent documents through the ICE SharePoint. The Pre-Audit Questionaire (PAQ) and supporting documentation was organized with the PREA Pre-Audit Policy and the Document Request DHS Immigration Detentions Facilities form and placed within folders for ease of auditing. The main policy that provides facility direction for LCDC is the Sexual Abuse and Assault Prevention and Intervention Program policy (SAAPI). All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Auditor for interviews with staff. The Auditor reviewed both the facility website, https://lcsomo.gov/jaildivision/ and the Agency website, www.ice.gov.

The entry briefing was held in the LCDC training room on April 25, 2023. The ICE ERAU TL opened the briefing. In attendance were:

(b) (6), (b) (7)(C) TL, Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU
(b) (6), (b) (7)(C) Section Chief (SC), ICE/OPR/ERAU
(b) (6), (b) (7)(C) Captain (Capt.), JA, LCDC
(b) (6), (b) (7)(C) Lieutenant (Lt.), LCDC
(b) (6), (b) (7)(C) Staff Sergeant (SSgt), LCDC
(b) (6), (b) (7)(C) SSgt, LCDC
(b) (6), (b) (7)(C) Assistant Field Office Director (AFOD), ICE/ERO
(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ERO
Jodi Upshaw, Auditor, Creative Corrections, LLC

The Auditor introduced herself and then provided an overview of the audit process and methodology to be used to demonstrate PREA Compliance with those present. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. She further explained compliance with the PREA standards will be determined based on review of policy and procedures, observations made during the facility tour, provided documentation for review, and conducting staff interviews. No correspondence was received from any detainee, outside individual, or staff member.

The audit commenced on April 25, 2023, and included the initial intake area, intake area, attorney visit room, master control, recreation area, and the medical unit. The initial intake area consists of a close watch cell with a capacity of one and a second cell with a capacity of two. There are three cells in the intake area with a capacity of five, six and nine. The intake holding cells have a toilet with sink and kiosk with telephone. Outside of the holding cells is a long-elevated desk for staff, benches, telephones, and a dress out room with a shower. The medical unit is located just off the intake area and has two examination rooms and two cells with a capacity of six and nine. Within each holding cell the Auditor observed the PREA audit notice, DHS-prescribed sexual assault awareness notice, with facility contact name and number, contact information for DHS Office of the Inspector General (OIG), reporting numbers for the ICE Detention Reporting and Information Line (DRIL), I Speak poster, and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet. All postings were in English and Spanish only. During the onsite audit, the Auditor noted sight lines, potential blind spots, and camera locations throughout (b) (7)(E). There were no detainees processed into LCDC during the onsite audit. The Auditor attempted to view video of the last detainee processed into the facility; however, the event was no longer viewable on the server (b) (7)(E).

LCDC has (b) (7)(E) located throughout all areas of the facility. The cameras run 24/7 and video footage is stored for up to (b) (7)(E) before being written over. The Auditor viewed camera site lines for direct viewing of (b) (7)(E) and confirmed camera angles provided privacy for female detainees (b) (7)(E);

however, the Auditor observed (b) (7)(E) that would enable direct viewing within the (b) (7)(E) of male detainees (b) (7)(E) (b) (7)(E). The (b) (7)(E) was in an enclosed room with (b) (7)(E). Cameras do not have the ability to tilt, pan or zoom (TPZ); however, they do record sound.

The facility has 30 staff positions with 23 security, 1 medical, 1 mental health, and the remainder consisting of non-security administrative, management, maintenance, and support staff. Food service is contracted through Summit Food Service; however, they do not have contact with detainees. The facility does not have any volunteers that have detainee contact. ICE staff come to the facility to drop off or pick up detainees.

The Auditor was provided with a staff roster for a random selection of formal interviews. The Auditor interviewed 13 staff members which consisted of the JA, the Prevention of Sexual Abuse (PSA) Compliance Manager, Medical Nurse (1), Human Resources (HR) staff (1), Investigative staff (1), Training Officer (TO) (1), Grievance Officer (GO) (1), Lt. (1), SSgts (2), and Detention Officers (DOs) (3). In addition, the Auditor interviewed two ICE staff consisting of the AFOD and SDDO.

The facility PAQ reported there is one facility investigator that has received specialized training on sexual abuse. There were no allegations of sexual abuse reported at LCDC during the audit period.

On April 27, 2023, an exit briefing was held in the Sheriff's conference room. The ICE/OPR/ERAU TL opened the briefing. In attendance were:

(b) (6), (b) (7)(C) TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C) SC, ICE/OPR/ERAU
(b) (6), (b) (7)(C) Lt., LCDC
(b) (6), (b) (7)(C) SSgt, PSA Compliance Manager, LCDC
(b) (6), (b) (7)(C) SSgt, LCDC
(b) (6), (b) (7)(C) AFOD, ICE/ERO
(b) (6), (b) (7)(C) SDDO, ICE/ERO
Jodi Upshaw, Auditor, Creative Corrections, LLC

The Auditor spoke briefly about non-compliance with training. The Auditor informed those in attendance that final compliance determinations could not be made until a review of documentation, site review notes, and interviews were compiled. The Auditor recognized the facility for their hard work in preparing for the audit and thanked those in attendance for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

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

Number of Standards Met: 18
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.34 Specialized training: Investigations
§115.52 Grievances
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.66 Protection of detainees from contact with alleged abusers
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 21
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§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
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.81 Medical and mental health assessments; history of sexual abuse
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

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

Notes:

(c)(d): LCDC policy SAAPI mandates, "Lincoln County Detention Center (LCDC) maintains a zero-tolerance policy for all forms of sexual abuse or assault. It is the policy of LCDC to provide a safe and secure environment for all detainees, employees, contractors, and volunteers, free from the threat of sexual abuse or assault, by maintaining a Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program that ensures effective procedures for preventing, reporting, responding to, investigating, and tracking incidents or allegations of sexual abuse or assault. The facility has a designated Prevention of Sexual Assault (PSA) Compliance Manager who serves as the facility point of contact for the local field office and ICE PSA Coordinator." During the onsite tour, the Auditor observed the DHS-prescribed sexual assault awareness notice in the holding cells and intake area in English and Spanish and the LCDC zero-tolerance posters in English. The Auditor also observed the facility zero-tolerance poster and the DHS-prescribed sexual assault awareness notice on facility tablets issued to detainees at intake. The Auditor reviewed the facility staffing plan and observed the PSA Compliance Manager reports to the Jail Lt. and the JA. In an interview with the PSA Compliance Manager, it was indicated he was the point of contact for the facility and Agency PSA Coordinator. In addition, the PSA Compliance Manager confirmed he has sufficient time and the authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. Interviews with security supervisors and three random DOs confirmed all were aware of the facility and Agency zero-tolerance policy toward all forms of sexual abuse. In an interview with the SDDO it was confirmed the Agency has reviewed and approved LCDC policy SAAPI.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "The facility ensures that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The facility administrator determines security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, the facility takes into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors." LCDC policy SAAPI further mandates, "Frequent unannounced security inspections shall be conducted to identify and deter sexual abuse of detainees. Inspections will occur on night as well as day shifts. Staff are prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility." The Auditor reviewed the facility PAQ which indicated LCDC employees 23 security staff (14 male and 9 female) with duty hours from 0500 – 1700 and 1700 – 0500. The remaining staff consists of administration, maintenance, medical, mental health contracted through Compass Health, and food service contracted through Summit Food Service. During the onsite audit, the Auditor did observe appropriate staffing levels in the intake area and medical area where detainees are housed. The intake desk is elevated to allow direct observation into the holding cells. There were monitors on the (b) (7)(E) and (b) (7)(E). There are a total of (b) (7)(E) located throughout the facility. Video cameras operate 24/7 and allow for sound, but do not have pan, tilt, and zoom, (PTZ) functionality. Cameras are continuously monitored by a staff member in the (b) (7)(E). Video feed can be observed on office computers located in (b) (7)(E), on the (b) (7)(E) and on the (b) (7)(E), (b) (7)(E), and (b) (7)(E). During the onsite tour, the Auditor observed adequate cameras within the (b) (7)(E), (b) (7)(E) and (b) (7)(E). The Auditor reviewed Booking Post Orders, Confinement Post Orders and Main Control Post Orders. Although these were provided for comprehensive detainee supervision guidelines and signed, they did not include a date to confirm an annual review had been conducted. During an interview, the JA indicated the Agency reviewed the comprehensive detainee supervision guidelines last month; however, no documentation was provided to confirm the review. In addition, the facility did not provide documentation to confirm when determining adequate levels of detainee supervision 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 recommendation 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 an interview with the JA it was confirmed he could not articulate what the facility would consider in determining adequate levels of detainee supervision and the need for video monitoring. In interviews with two SSgts., it was indicated facility safety inspections were conducted every hour; however, were not documented. Therefore, as unannounced security inspections were not documented the Auditor could not confirm they were conducted in accordance with subsection (d) of the standard. In addition, although policy review confirms the facility prohibits staff from alerting others about unannounced security inspections, interviews with three random DOs could not confirm knowledge of the practice.

Does Not Meet (b)(c)(d): The facility is not in compliance with subsections (b), (c) and (d) of this standard. In an interview with the JA, it was indicated that the comprehensive detainee supervision guidelines were reviewed last month by the Agency; however, no documentation was provided to confirm the review. The facility did not provide documentation to confirm when determining adequate levels of detainee supervision 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 recommendation 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, the facility did not provide documentation that unannounced security inspections to identify and deter sexual abuse of detainees are being conducted. In interviews with three random DOs, it was confirmed they were unaware of the standards requirement not to alert other staff when unannounced security inspections are being conducted. To become compliant the facility must provide the Auditor with documentation to confirm that LCDC's comprehensive detainee supervision guidelines have been reviewed for the year 2023. In addition, documentation must be provided to confirm when determining adequate staffing levels and the need for video monitoring, the facility took into consideration the physical layout of each holding 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. The facility must also implement a practice that requires supervisors to make frequent unannounced security inspections on both day and night shifts to identify and deter sexual abuse of detainees as required by the standard. Once implemented the facility must submit documentation to confirm all supervisors were trained in conducting unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees. The facility must submit documentation to confirm all security staff have been trained on the standards requirement not to alert others while unannounced security inspections are being conducted. The facility must submit to the Auditor documentation of unannounced security inspections for the purpose of identifying and deterring sexual abuse of detainees for each month of the Corrective Action Plan (CAP) period.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b)(c)(d): According to the PAQ, and interviews with the JA and PSA Compliance Manager, LCDC does not accept juvenile or family unit detainees; and therefore, the standard is not applicable.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(c)(d)(e)(f)(i): LCDC policy SAPPI mandates, "Viewing and Search Requirements for Detainees of the Opposite Gender a) pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances; b) pat-down searches of female detainees by male staff shall not be conducted unless in exigent circumstances; c) all pat-down searches by staff of the opposite gender shall be documented; d) strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner; e) all strip searches and visual body cavity searches shall be documented; g) the facility does 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 medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner; h) all pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner as possible, consistent with security needs and policy, including officer safety." The Auditor reviewed a memorandum from the JA which stated that no cross-gender searches or strip searches were conducted by staff during the audit period. The facility also provided two logs entitled, Cross-Gender Search Log and Strip/Body Cavity Search Log which included entries for date, start time, detainee name and number, the purpose of search and officer name. The logs would be utilized should a cross-gender pat-down search, or strip/body cavity search be conducted. Interviews with three random DOs confirmed cross-gender pat-down searches, strip searches, or visual body cavity searches have not been conducted during the audit period; however, all staff were able to articulate the standard's requirement to document the search. In addition, in interviews with three random DOs it was confirmed staff was knowledgeable in how to conduct a proper pat-down search of a detainee and they would not search a detainee for the sole purpose of determining the detainee's genital characteristics.

(g): LCDC policy SAPPI mandates, "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 bowl 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." The Auditor viewed camera site lines for direct viewing of shower, toilet, and clothing changing areas and confirmed camera angles provided privacy for female detainees using the bathroom or changing; however, the Auditor observed (b) (7)(E) that would enable direct viewing within the (b) (7)(E) of male detainees (b) (7)(E). The shower area was in an enclosed room (b) (7)(E) (b) (7)(E). As there were no detainees housed at LCDC during the onsite audit the Auditor could not observe cross-gender staff announcements when entering an area that detainees would likely be showering, performing bodily function, or changing clothing.

Does Not Meet (g): The facility is not in compliance with subsection (g) of this standard. While viewing the cameras the Auditor did observe (b) (7)(E) within the (b) (7)(E) that allowed direct viewing should a male detainee be performing bodily functions. To become compliant the facility must implement a practice that provides privacy for all detainees to perform bodily functions without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine jail checks.

(h): LCDC is not designated as a Family Resident Center; therefore, provision (h) is not applicable. (j): There were no detainees processed into the facility during the onsite audit. The Auditor attempted to view video of the last detainee processed into the facility; however, the event was no longer viewable on the server due to limited storage. In an interview with the TO it was indicated staff receive online training through the National Institute of Corrections website. Interviews with three DOs confirmed that all had received training on conducting pat-down searches and they were knowledgeable on how to conduct cross-gender pat-down searches and searches of transgender and intersex detainees. During the onsite audit, the Auditor observed staff transcripts of completed training.

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

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

Notes:

(a)(b)(c): LCDC policy SAPPI mandates, "The facility does take appropriate steps to ensure 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 visions, by: 1) 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; 2) Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication." LCDC policy SAPPI further mandates, "The facility takes 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, the facility shall employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. The facility provides detainees with disabilities and detainees with limited English proficiency with 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 ICE/ERO determines 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 and assault." During the onsite audit, the Auditor observed the PREA audit notice, DHS-prescribed sexual assault awareness notice with facility contact name and number, contact information for DHS OIG, reporting numbers for the DRIL, I Speak poster, and the DHS-prescribed SAA Information pamphlet in English and Spanish posted within the holding cells and the around the telephones in the intake area. In addition, the Auditor observed the consulate information on the holding cell kiosks. Through observation the Auditor was able to confirm detainees receive PREA information, including information on the zero-tolerance policy, telephone numbers for the DRIL line and information about what to do should a sexual assault occur on facility issued tablets in English only. The Auditor reviewed the tablet and confirmed on first use the detainee must read the jail rules and PREA information, and then press a button entitled, "Acknowledge and Understand." If the detainee does not press the button, they will not have access to the tablet. In addition, the Auditor was able to confirm the facility uploaded the ICE National Detainee Handbook onto kiosks located in each holding cell in English and Spanish. In an interview with an intake DO it was indicated if the detainee needed to access the ICE National Detainee Handbook in a language other than English or Spanish, he/she could do so by way of Google Translate. The DO assigned to intake further indicated should a detainee speak a language other than English or Spanish; staff would assist with the Google translation services on the kiosk and the facility has access to Language Services Section (LSS) for interpreter services if the need arises. In an interview with the JA and an intake DO it was further indicated if a detainee had a hearing disability, the Department of Health or one of several Sheriff's Deputies could be contacted who know sign language. Should a detainee have a vision disability, the DO articulated that information could be read to them. Should a detainee have an intellectual, psychiatric, speech disability or limited reading skills, the DO indicated multiple ways they could provide PREA information such as, speaking slowly or speaking in vocabulary the detainee could understand. The DO assigned to intake further confirmed there were a few Spanish speaking DOs that could interpret if needed. Interviews with three random DOs confirmed they would not allow one detainee to interpret for another in an allegation of sexual abuse unless it was approved. Although staff could not articulate specifically that it would be an Agency determination that was appropriate and consistent with DHS policy, staff knew to contact a supervisor for further guidance. Interviews with three security supervisors confirmed ICE would be consulted if needed.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

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 serve 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. A review of all submitted LCDC policies confirms that LCDC does not have a policy that mandates the requirements of standard 115.17. The Auditor reviewed the LCSO employment application and confirmed the applicant must sign a statement that information on the application is correct and that any misrepresentation or omission of fact on this or any record submitted pertinent to employment will constitute grounds for refusal to hire or immediate dismissal, regardless of when the false answer or omissions are discovered; however, it does not require the applicant who may have contact with detainees to disclose if he/she had engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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 Auditor reviewed the personnel files of nine facility staff and confirmed background checks were completed prior to employment; however, a file review of a staff member promoted during the audit period, in conjunction with an interview, confirmed he was not asked about previous misconduct prior to receiving his promotion as required by subsection (b) of the standard. In addition, the Auditor was provided with a memorandum that stated, "Staff take annual PREA/SAAPI training that includes the standards requirement to impose upon staff a continuing duty to report sexual misconduct; however, the Auditor was not provided with documentation to confirm that staff had attended the training or acknowledged their duty to do so." In an interview with HR staff, it was confirmed that information would be shared regarding substantiated allegations of sexual abuse with potential employers according to the law. The facility did not maintain contractor files; and therefore, the Auditor could not confirm the one mental health employee contracted through Compass Health received PREA training as required by the standard. Interviews with the AFOD and SDDO indicated there were no recent ICE promotions or hires during the audit period. The Auditor submitted a Background Investigation for Employees and Contractors form to the OPR PSO Unit which included two ICE employees assigned to the facility to verify the completion of the background process. OPR PSO confirmed background investigations and the required five-year investigations were completed for all staff submitted. There are no volunteers at LCDC who provided services to detainees at LCDC during the audit period.

Does Not Meet (a)(b)(c)(d): The facility is not in compliance with subsections (a), (b), (c), and (d) of this standard. The Auditor reviewed the LCSO employment application and confirmed it does not require the applicant who may have contact with detainees to disclose if he/she had engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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 Auditor interviewed and reviewed the personnel file of a facility staff member promoted during the audit period and confirmed they were not asked about previous misconduct as required by subsection (b) of the standard. The facility did not provide documentation that staff members have received training that includes their continuing duty to report sexual misconduct or acknowledged their duty to do so. The facility did not provide the Auditor with any files of contract staff who may have contact with detainees. To become compliant, the facility must implement a practice that requires the facility not hire, promote, or use the services of any individual, including staff and contractors who have engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community 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. In addition, the facility must implement a practice that requires staff being considered for promotion be asked in written application, or interview, about previous sexual misconduct and to require that all staff have a continuing affirmative duty to report any misconduct involving sexual abuse. The facility must provide the Auditor with the file of the mental health employee contracted through Compass Health to confirm the contractor did not engage in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings within the community or attempted 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 been civilly or administratively adjudicated to have engaged in such activity prior to providing services to the detainee population. Once implemented the facility must train all applicable staff on the new procedures. The facility must provide the Auditor with 10 personnel files to confirm compliance with subsections (a) and (b) of the standard. If applicable, the facility must provide the Auditor with the personnel files of any staff member, including ICE, who receive a promotion during the CAP period.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): LCDC policy SAPPI mandates, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility considers the effect of the design, acquisition, expansion, or modification upon its ability to protect detainees from sexual abuse and assault. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, the facility considers how such technology may enhance its ability to protect detainees from sexual abuse and assault." A review of the PAQ and interviews conducted with the JA confirmed the facility has not acquired a new facility or made a substantial expansion to the existing facility or installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology during the audit period. Therefore, subsections (a) and (b) of the standard are not applicable.

§115.21 – Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): The Agency's policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI), 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." LCDC SAPPI further mandates, "When evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination by a Sexual Assault Forensic 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. In the event the investigation is being conducted by a non-federal investigating agency, the facility shall request that the investigating agency follow the applicable requirements of this policy, including requirements related to evidence preservation and forensic examinations." LCDC policy SAAPI states, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse and assault perpetrators to most appropriately address victims' needs." LCDC policy SAAPI further states, "Where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), where practicable. If SAFEs or SANEs cannot be made available, the forensic medical examination can be performed by other qualified health care personnel." In addition, LCDC policy SAAPI states, "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." Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource for crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide services following an incident of sexual abuse. During the onsite audit, the mental health professional from Compass Health came to the facility; however, excited before the Auditor could conduct an interview. The Auditor attempted to contact the mental health professional from Compass Health via telephone; however, calls have not been returned. The Auditor contacted an emergency nurse from Lincoln Mercy Hospital and was able to confirm a SANE is available to provide forensic medical examinations as needed. In addition, the emergency nurse was able to confirm that a victim's advocate would be made available during a forensic exam; however, the nurse could not confirm the advocate would be available during investigatory interviews. In an interview with the facility nurse it was confirmed a SANE would be made available at no cost to the detainee. In the interview with the JA, it was confirmed that the Lincoln County Sheriff's Office (LCSO) is responsible for conducting administrative and criminal sexual abuse investigations. The JA further advised if during the investigation it is determined the reported allegation is criminal in nature, it would be referred to the LCSO. In addition, the JA confirmed both entities are part of the same agency; and therefore, are required to follow the requirements of subsection (a) of the standard. The JA further confirmed should there be a conflict of interest with involved parties the Missouri State Police (MSP) would investigate the incident. In an interview with the PSA Compliance Manager, it was indicated LCDC would request the MSP follow the requirements of subsections (a) through (d) of the standard; however, the facility did not submit documentation to confirm the facility did so. In an interview with the SDDO it was confirmed LCDC policy SAAPI was established in consultation with DHS. There were no allegations of sexual abuse reported at LCDC during the audit period.

Does Not Meet (b)(d)(e): The facility is not in compliance with subsections (b), (d), and (e) of this standard. Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource for crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide services following an incident of sexual abuse. The Auditor contacted an emergency nurse from Lincoln Mercy Hospital and was able to confirm that a victim's advocate would be made available during a forensic exam; however, the nurse could not confirm the advocate would be available during investigatory interviews. In an interview with the PSA Compliance Manager, it was indicated LCDC would request the MSP follow the requirements of subsections (a) through (d) of the standard; however, the facility did not submit documentation to confirm the facility did so. To become compliant, the facility must coordinate with a community resource to provide advocacy services to the detainee victim during the investigation process. The facility must provide documented training of all applicable staff regarding staff responsibility to provide the detainee victim with all requirements of the standard. In addition, the facility must provide documentation that the facility requested the MSP to follow paragraphs (a) through (d) of the standard. If applicable, the facility must provide the Auditor with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (b) and (d) of the standard.

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

Outcome: Does not Meet Standard (requires corrective action)

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)." LCDC policy SAAPI mandates, "The facility to establish a protocol, to ensure each allegation of sexual abuse is investigated by facility or referred to an appropriate investigative authority. This protocol shall be posted on the facility website, or otherwise made available to the public." LCDC policy SAPPI further mandates, "The facility coordinates with ICE/ERO and other appropriate investigative entities to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse." LCDC policy SAAPI further states, "Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years" and "coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." In addition, LCDC policy SAAPI states, "If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the facility administrator notifies the local government entity or contractor that operates the facility and ICE/ERO. The same notifications are made if a detainee, prisoner, inmate, or resident of the facility is the alleged perpetrator of the sexual abuse" and "the facility administrator promptly reports the incident to the ICE/ERO FOD and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. The facility may separately, and in addition to the required reports and referrals, conduct its own investigation." A review of LCDC policy SAAPI confirms the established protocol does not include notifying the Joint Intake Center (JIC), ICE OPR or the DHS OIG. In addition, the established protocol does not include a description of responsibilities of the Agency, facility, and other investigative entity. Interviews with the JA, PSA Compliance Manager, and Investigator indicated that all allegations of sexual abuse would be referred for investigation and that such records will be maintained in hard copy and electronic format indefinitely. Interviews further indicated when a detainee, prisoner, inmate, or resident of the facility where the detainee victim is a housed is alleged to be the perpetrator of detainee sexual abuse or staff member, contractor or volunteer is the perpetrator of detainee sexual abuse, the facility will notify the appropriate ICE FOD and appropriate investigative authority. In an interview with the SDDO it was confirmed he would be notified immediately and would immediately notify the AFOD, who in turn would notify the JIC and ICE OPR or DHS OIG. The Auditor reviewed the facility's website, https://lcsomo.gov/jaildivision/ and the Agency website, www.ice.gov and confirmed that the Agency website includes the Agency investigative protocol; however, the facility website does not include the required facility investigative protocol.

Does Not Meet (a)(b)(c)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (c), (d), (e), and (f) of the standard. A review of LCDC policy SAAPI confirms it does not contain the requirement 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 JIC, the ICE OPR or DHS OIG. In addition, a revie3w of LCDC policy SAAPI further confirms it does not contain the requirement 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 incident is promptly report to the JIC, the ICE OPR or DHS OIG. A review of LCDC policy SAAPI further confirms it does not include a description of responsibilities of the Agency, facility, and other investigative entity; and therefore, although the facility has established a protocol it does not contain all required elements of the standard. The Auditor reviewed the facility website https://lcsomo.gov/jaildivision/ and confirmed LCDC policy SAAPI is not posted as required by subsection (c) of the standard. To become compliant the facility must update LCDC policy SAAPI to include the requirements 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 JIC, the ICE OPR or DHS OIG, and 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 incident is promptly report to the JIC, the ICE OPR or DHS OIG. In addition, the facility must update LCDC policy SAAPI to include a description of responsibilities of the Agency, facility, and other investigative entity. Once updated, the facility must train all applicable staff on the updated LCDC policy SAAPI and include the policy on the facility website https://lcsomo.gov/jaildivision/.

§115.31 – Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): The Agency's policy 11062.5.2 mandates, "The Agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed training." LCDC policy SAAPI mandates, "Training on the facility's Sexual Abuse and Assault Prevention and Intervention Program shall be included in initial training for all employees and shall also be included in the annual refresher training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under this standard and shall include: a) the facility's zero-tolerance policies for all forms of sexual abuse; b) definitions and examples of prohibited and illegal sexual behavior; c) the right of detainees and staff to be free from sexual abuse, and from retaliation from reporting sexual abuse; d) instruction that sexual abuse and/or is never an acceptable consequence of detention; e) recognition of situations where sexual abuse and/or sexual assault may occur; f) how to avoid inappropriate relationships with detainees; g) working with vulnerable populations and addressing their potential vulnerability in the general population; h) recognition of the physical, behavioral, and emotional signs of

sexual abuse and/or sexual assault and ways to prevent and respond to such occurrences; i) 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; j) the investigation process and how to ensure that evidence is not destroyed; k) prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; l) how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; m) instructions on reporting knowledge or suspicion of sexual abuse and/or assault; and n) instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault." LCDC policy SAPPI further mandates, "The facility shall maintain documentation verifying employee, volunteer and contractor training." In an interview with the TO it was confirmed staff training is conducted through a NIC course entitled "PREA: Your Role in Responding to Sexual Abuse." The Auditor is familiar with the training and can confirm it meets the requirements under subsection (a) of the standard. During the onsite audit, the Auditor conducted a review of nine staff training files and confirmed staff have received the required two-year refresher training; however, the Auditor was not provided with documentation that confirms a mental health employee contracted through Compass Health has completed the required training. In interviews with the AFOD and SDDO, it was indicated ICE staff training is completed yearly and historical records were located within PALMS; however, ICE training records were not provided.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. In interviews with the AFOD and SDDO it was indicated ICE staff training is completed yearly and historical records are located within PALMS; however, ICE training records were not provided. In addition, the Auditor was not provided with documentation that confirms a mental health employee contracted through Compass Health has completed the required training. To become compliant the Agency must provide documentation that all ICE employees who have contact with detainees at LCDC have received documented PREA training as required by subsections (a), (b), and (c) of the standard. In addition, the facility must provide the Auditor with documentation that the mental health employee contracted through Compass Health has completed the training required under subsection (a) of this standard.

§115.32 – Other training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "All volunteers and other contractors who have contact with detainees shall be 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 ICE/ERO and 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. The facility will maintain documentation verifying employee, volunteer, and contractor training." In an interview with the JA, it was confirmed training is not completed for other contractors who enter the facility. There were no volunteers who provided services to detainees during the audit period.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. In an interview with the JA, it was confirmed that training is not completed for other contractors who enter the facility. To become compliant, the facility must submit to the Auditor documentation that all other contractors at LCDC who have contact with detainees have been trained on their responsibilities under the Agency's and facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training shall be based on the services provided, but at minimum, other contractors should be notified of the Agency's and the facility's zero-tolerance policies regarding sexual abuse and informed how to report such incidents.

§115.33 – Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): LCDC policy SAAPI mandates, "Upon admission Lincoln County Detention Center, all detainees shall be notified of the facility's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee handbook and provided with information about the facility's SAAPI Program. Such information shall include, at a minimum: a) the facility's zero tolerance policy for all forms of sexual abuse or assault; b) the name of the facility PSA compliance manger, and information about how to contact him/her; c) prevention and intervention strategies; d) definitions and examples of detainee-on-detainee sexual abuse and assault, staff on-detainee sexual abuse and assault and coercive sexual activity; e) 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 DHS/OIG and the ICE/OPR investigations processes; f) information about self-protection and indicators of sexual abuse and assault; g) prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and h) the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The facility provides the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The facility maintains documentation of detainee participation in the instruction session. The facility posts on all housing unit bulletin boards the following notices: 1) the ICE/ERO prescribed sexual abuse and assault awareness notice; 2) the name of the PSA Compliance Manager; and 3) Information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (incl. toll-free hotline numbers where available). If no such local organizations exist, the facility makes available the same information about national organizations. The information will be provided in English and

Spanish and to other segments of the detainee population with limited English proficiency through translations or oral interpretations. The facility makes available and distribute the ICE/ERO-prescribed "Sexual Assault Awareness Information" pamphlet. Information about reporting sexual abuse shall be included in the ICE Detainee Handbook made available to all immigration detainees at the facility." During the onsite audit, the Auditor observed the consulate contact information, the DHS-prescribed sexual assault awareness notice, with facility contact name and number, contact information for the DHS OIG, reporting numbers for the DRIL, I Speak poster, and the DHS SAA Information pamphlet in English and Spanish; however, did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse. The Auditor reviewed the detainee tablets and kiosks located in the holding cells and was able to confirm that detainees receive PREA information, including information on the zero-tolerance policy, telephone numbers for the DRIL line, and information about what to do should a sexual assault occur. The information was available on the tablet in English only and on the kiosks in English and Spanish. The Auditor further confirmed on the first use of the tablet the detainee must read the jail rules and PREA information, and then press a button entitled, "Acknowledge and Understand." If the detainee does not press the button, they will not have access to the tablet. In addition, the Auditor was able to confirm the facility uploaded the DHS-prescribed SAA Information pamphlet and ICE National Detainee Handbook onto the tablets in English and on the kiosks located in each holding cell in English and in Spanish. In an interview with an intake DO it was indicated if the detainee needed to access the ICE National Detainee Handbook and/or the DHS-prescribed SAA Information pamphlet in a language other than English or Spanish, he/she could do so by way of Google Translate. The DO assigned to intake further indicated should a detainee speak a language other than English or Spanish; staff would assist the detainee to access the google translation services on the devices. In an interview with an intake DO it was further indicated; the facility has access to Language Services Section (LSS) for interpreter services if the need arises. In an interview with the JA and an intake DO it was indicated if a detainee had a hearing disability, the Department of Health or one of several Sheriff's Deputies could be contacted who know sign language. Should a detainee have a vision disability, the DO articulated that information could be read to them. Should a detainee have an intellectual, psychiatric, speech disability or limited reading skills, the DO indicated multiple ways they could provide PREA information such as, speaking slowly or speaking in vocabulary the detainee could understand. The DO further confirmed that there were a few Spanish speaking DOs that could interpret if needed. The Auditor was provided with the LCDC orientation PowerPoint slides which are located on both devices and confirmed they contain the information required by subsection (a) of the standard; however, a review of the detainee tablet and kiosks could not confirm the detainee participated in an orientation process or was able to access the PREA information in a manner he/she could understand. The Auditor reviewed the ICE National Detainee Handbook and confirmed the handbook includes information about reporting sexual abuse.

Does Not Meet (c)(d): The facility is not in compliance with subsection (c) and (d) of this standard. The Auditor reviewed the detainee tablets and kiosks located in the holding cells and was able to confirm that detainees receive PREA information, including information on the zero-tolerance policy, telephone numbers for the DRIL line, and information about what to do should a sexual assault occur; however, a review of the detainee tablet and kiosks could not confirm the detainee participated in an orientation process or was able to access the PREA information in a manner he/she could understand. During the onsite audit the Auditor did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse. To become compliant, the facility must implement a practice that documents all detainees receive a PREA orientation in a manner that he/she could understand. In addition, the facility must post the name of a local organization that can assist detainee victims of sexual abuse on the housing unit bulletin boards.

§115.34 – Specialized training: Investigations.

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

Notes:

(a)(b): 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." LCDC policy SAAPI mandates, "In addition to general training, all facility staff responsible for conducting sexual abuse or assault investigations shall receive specialized training that covers, at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement setting, 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 requirement." The Auditor observed a completed training certificate from NIC for the course: PREA: Investigating Sexual Abuse in a Confinement Setting for the facility Investigator. The Auditor reviewed the training curriculum and confirmed it included all elements required by the standard. In an interview with the facility investigator, it was confirmed he was knowledgeable in conducting sexual abuse allegation investigations.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): The facility does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners, and therefore, this standard is not applicable.

(b)(c): LCDC policy SAAPI mandates, "Facility medical staff shall be trained in procedures for examining and treating 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 ICE/ERO. Such specialized training shall include detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse and assault, and how and to whom to report allegations or suspicions of sexual abuse or assault. The facility maintains documentation verifying employee, volunteer, and contractor training." The Auditor observed the nurse's PREA transcript

onsite and confirmed she has completed the NIC course entitled "PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting." The Auditor is familiar with this curriculum and can confirm that it meets the requirements under subsection (b) of the standard. The Auditor was not provided training documentation to confirm a mental health employee contracted through Compass Health has completed the required training. In an interview with the SDDO it was confirmed the Agency has reviewed and approved LCDC policy SAAPI.

Does Not Meet (b): The facility is not in compliance with subsection (b) of this standard. The facility did not provide documentation to confirm a mental health employee contracted through Compass Health has completed training as required under subsection (b) of the standard. To become compliant, the facility must submit documentation that confirms the mental health employee contracted through Compass Health has completed the training as required under subsection (b) of this standard.

§115.41 – Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f)(g): LCDC policy SAAPI mandates, "All detainees are screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. The facility uses the assessment to inform assignments of detainees to recreation and other activities, and voluntary work. Each new detainee shall be kept separate from the general population until he/she has been 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 considers, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: a) whether the detainee has a mental, physical, or developmental disability; b) the age of the detainee; c) the physical build and appearance of the detainee; d) whether the detainee has previously been incarcerated or detained; e) the nature of the detainee's criminal history; f) whether the detainee has any convictions for sex offenses against an adult or child; g) whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; h) whether the detainee has self-identified as having previously experienced sexual victimization; and i) the detainee's own concerns about his or her physical safety. Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to items a, g, h, or I, above. The initial screening shall consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive. The facility has appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates." LCDC policy SAAPI further mandates, "The facility shall reassess each detainee's risk of abusiveness between 60 and 90 days from the date of the initial assessment, and any other time when warranted based upon the receipt of addition, relevant information, or following an incident of abuse or victimization." The Auditor reviewed the provided Risk Classification Assessment (RCA) completed by ICE and confirmed the RCA screening takes into consideration whether the detainee has a mental, physical or developmental disability, the age of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as a transgender, whether the detainee has self-identified as having previously experienced sexual victimization, prior convictions for violent offenses, a history of prior institutional violence, and the detainee's own concerns about his or her physical safety; however, it does not consider whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. The Auditor was not able to observe the intake process for a detainee; however, in an interview with a DO assigned to intake it was indicated all detainees would be kept separate on benches within the intake area until they are classified. The detainee would then be housed within one of the cells located within the intake area. The DO assigned to intake further indicated the intake process would normally be completed within one hour of the detainee's arrival. In addition, the DO assigned to intake indicated should a detainee identify as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming it would be placed in an "Alerts" section of the system. In an interview with a staff member responsible for inmate/detainee accounts, and a review of her access to the detainee file, it was confirmed although the staff person did not have a need to know the detainee's responses to questions asked pursuit to standard 115.41, she had access to all areas of the system to include the "Alerts" area where sensitive information disclosed by the detainee during the risk screening would be entered. In an interview with intake staff, it was indicated a reassessment would be conducted after a disciplinary sanction; however, the facility would not conduct a reassessment between 60-to-90-days from the initial assessment, after the initial assessment, after an incident of abuse or victimization, or following the receipt of additional information as required by the standard. Intake staff further indicated a detainee would not be disciplined for refusing to answer, or for not disclosing complete information in response to the intake screening.

Does Not Meet (a)(c)(d)(e)(g): The facility is not compliant with subsections (a), (c), (d), (e), and (g) of the standard. The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. In an interview with a staff member responsible for inmate/detainee accounts, and a review of her access to the detainee file, it was confirmed although the staff person did not have a need to know the detainee's responses to questions asked pursuit to standard 115.41, she had access to the "Alerts" area on the computer screen that included the sensitive information disclosed by detainees during the risk screening. In an interview with intake staff, it was indicated a reassessment would not be conducted between 60-to-90-days from the initial assessment, after the initial assessment, after an incident of abuse or victimization, or following the receipt of additional information as required by the standard. To become compliant, the facility must update their current practice of assessing detainees at intake to identify those likely to be sexual aggressors or sexual abuse victims to include whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has

self-identified as gay, lesbian, bisexual, or gender nonconforming and any prior acts of sexual abuse. The facility must implement a practice that requires all detainees be reassessed between 60-to-90-days from the initial assessment, after the initial assessment, after an incident of abuse or victimization, or following the receipt of additional information as required by the standard. In addition, the facility must implement a practice that ensures appropriate controls were placed on the dissemination of the responses to the initial risk assessment. Once implemented the facility must submit documentation that all applicable staff, including intake and classification staff, have received training on the implemented practices. The facility must submit documentation that only staff with a need to know have access to the detainee's responses to questions asked pursuit to standard 115.41. The facility must submit the files of 10 detainees received during the CAP period to confirm the facility has implemented the required practices. If applicable, the facility must provide the Auditor with 10 detainee files that include reassessments of detainee's risk of victimization and abusiveness, between 60-and-90 days of the initial assessment. In addition, the facility must provide the Auditor with all sexual abuse allegation investigation files that occurred during the CAP period to confirm the detainee victim was reassessed for risk of sexual victimization after an incident of sexual abuse.

§115.42–- Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "All detainees are screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. The facility uses the assessment to inform assignment of detainees to recreation and other activities, and voluntary work." LCDC policy SAAPI further mandates, "When making assessment and housing decisions for a transgender or intersex detainee, the facility considers the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility does 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 a year to review any threats to safety experienced by the detainee. When operationally feasible transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening takes into consideration whether the detainee has a mental, physical or developmental disability, the age of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as a transgender, whether the detainee has self-identified as having previously experienced sexual victimization, prior convictions for violent offenses, a history of prior institutional violence, and the detainee's own concerns about his or her physical safety; however, it does not consider whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. In an interview with the nurse, it was indicated intake does not consult with medical prior to making housing decisions for a transgender or intersex detainee. In addition, the nurse indicated that the facility does not conduct a reassessment of a transgender or intersex detainee's placement twice a year to review any threats to his/her safety. Interviews with intake staff confirmed that housing decisions would be made based on security and not a detainee's gender self-identification or an assessment of th14ffectcts of placement on the detainee's health and safety. Interviews with the PSA Compliance Manager and three random DOs confirmed a transgender or intersex detainee would be able to shower separately. Interviews with the JA and PSA Compliance Manager confirmed that a transgender or intersex detainee has not been housed at the facility during the audit period.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming. Therefore, the facility does not have a viable risk assessment as required under standard 115.41 and subsequently will be not compliant with subsection (a) of this standard. In an interview with the nurse, it was indicated intake does not consult with medical prior to making housing decisions for a transgender or intersex detainee. In addition, the nurse indicated that the facility does not conduct a reassessment of the transgender or intersex detainee's placement to review any threats to his/her safety. Interviews with intake staff confirmed that housing decisions would be made based on security and not a detainee's gender self-identification or an assessment of the effects of placement on the detainee's health and safety. To become compliant the facility must update their current practice of assessing detainees at intake to identify those likely to be sexual aggressors or sexual abuse victims to include whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as gay, lesbian, bisexual, or gender nonconforming and any prior acts of sexual abuse. In addition, the facility must implement a practice that requires in making assessment and housing assignments for transgender and intersex detainees the facility considers the detaine" s gender self-identification and an assessment of the effects of placement on the detaine"s health and safety and based on security classification only. The facility must implement a practice that includes consulting with medical and mental health professionals as soon as practicable when a transgender or intersex detainee is assigned to their initial housing. In addition, the facility must implement a practice that includes conducting a reassessment of a transgender or intersex detainee's placement twice a year to review any threats to his/her safety. Once implemented the facility must submit documentation that all intake, classification, medical, and mental health staff, have received training on the new procedure. The facility must submit files of 10 detainees received during the CAP period. If applicable the facility must submit to the Auditor any transgender or intersex detainee who arrives at LCDC during the CAP period.

§115.43–- Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): LCDC policy 3.15.1, SMU Procedures/Housing Standards states, "A detainee considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director to determine if ICE can provide additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days." LCDC policy 3.15.1 further states, "Detainees in SMU shall have access to programs and services such as commissary, library, religious guidance and recreation." A review of LCDC policy 3.15.1 confirms the facility does not have written procedures that require the facility: 1) clearly document the basis for the facilit"s concern for the detainee's safety; and the reasons why no alternative means of separation can be arranged; 2) require a supervisory staff member conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter; and 3) notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. The Auditor reviewed a memorandum that reviews would be conducted within 72 hours of placement, every 7 days for the first month and then, if necessary, every 10 days thereafter and that the facility would notify ICE within 72 hours by email should a detainee be placed in protective custody or administrative segregation. In an interview with the JA, it was indicated notifications would be made to ICE immediately and proper reviews would be conducted at the appropriate times and documented. There were no allegations of sexual abuse reported during the audit period. In an interview with the JA, it could not be confirmed that LCDC policy 3.15.1 was developed in consultation with the ICE/ERO FOD having jurisdiction over the facility.

Does Not Meet (a)(d)(e): The facility is not in compliance with subsections (a), (d), and (e) of the standard. A review of LCDC policy 3.15.1 confirms the facility does not have written procedures that require the facility: 1) clearly document the basis for the facilit"s concern for the detainee's safety; and the reasons why no alternative means of separation can be arranged, require a supervisory staff member to conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter; and 3) notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. In an interview with the JA, the Auditor could not confirm LCDC policy 3.15.1 was developed in consultation with the ICE/ERO FOD having jurisdiction over the facility. To become compliant the facility must updated LCDC 3.15.1, in consultation with the ICE/ERO FOD having jurisdiction over the facility, to include the facility will clearly document the basis for the facility's concern for the detainee's safety; and the reasons why no alternative means of separation can be arranged, a supervisory staff member shall conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter, and the facility shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. Once updated the facility must train all security staff on the updated LCDC policy 3.15.1. If applicable, the facility must submit to the Auditor the files of any detainees placed in protective custody due to being vulnerable to sexual abuse or assault during the CAP period.

§115.51–- Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "Detainees shall have multiple ways to privately and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting." and "staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." LCDC policy SAPPI further mandates, "Detainee reports of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents may be made using any available methods of communication, including but not limited to: 1) verbal reports to any staff member (including the PSA Compliance Manager or medical staff); 2) written informal or formal requests of grievances to the facility; 3) sick call requests; 4) reports to an individual or organization outside the facility (family members, friends, or other outside entities) who can contact facility staff; 5) written informal or formal requests or grievances (including emergency grievances) to the ICE/ERO; 6) telephone calls or written reports to the DHS/OIG, ICE/OPR, or ICE/DRIL; and 7) telephone calls or written reports to consular officials." During the onsite audit the Auditor observed within each holding cell the PREA audit notice, DHS-prescribed sexual assault awareness notice, with the facility PSA Compliance Manager's name and number, reporting numbers for the DRIL, contact information for the DHS OIG, I Speak poster, and the DHS SAA Information pamphlet in English and Spanish. The Auditor also observed consulate contact numbers scrolling on the kiosk system located within each cell. The ICE Detainee Handbook with reporting numbers can be accessed on the kiosk and translated utilizing Google Translate in over 100 languages. The Auditor also reviewed the orientation PowerPoint located on the kiosk and confirmed it includes several resources on how a detainee could report retaliation or staff neglect or violations that may have contributed to such incidents and specific instruction on avenues to report anonymously and can be translated into the detainee's preferred language utilizing Google Translate. During the onsite audit, the Auditor attempted to place calls to the DHS OIG and to the ICE DRIL posted telephone numbers. The Auditor was unable to complete the calls as the line would disconnect. Interviews with three random DOs confirmed they would accept reports made verbally, in writing, anonymously and from third parties and they would promptly document any verbal reports.

Does Not Meet (a): The facility is not in compliance with subsections (a) of this standard. The Auditor attempted to call the DHS OIG and ICE DRIL posted telephone numbers; however, the line would disconnect. To become compliant, the facility must submit documentation that confirms each number provided to the detainees for reporting sexual abuse is in good working order.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f): LCDC policy 3.12, Grievance Procedure, mandates, "Emergency grievances which may involve an immediate threat to a detainee/offender's health, safety or welfare will be responded to in an expedition manner. Once the receiving employee is approached by a detainee/offender and determines that he or she is in fact raising an issue requiring urgent attention, emergency grievance procedures shall apply. Translation services will be available upon request. The protocol for emergency grievance procedures shall bring the matter to the immediate attention of the Jail Administrator, or designee, even if it is later determined that it is not a true emergency, and the grievance is subsequently routed through normal, non-emergency channels. Medical emergencies shall be brought to the immediate attention of proper medical personnel for further assessment. The detainee/offender may elect to present his or her emergency directly to the Shift Supervisor or Contract Equivalent. If the on-duty Shift Supervisor concurs that the grievance represents an emergency, it shall receive the immediate attention of the Jail Administrator. If the matter is resolved at the shift level, the Supervisor involved shall prepare a report for the Jail Administrator, or designee, describing the problem and the resolution." LCDC policy 3.12.4, Grievance Resolution and Response, mandates, "Resolution is absent an emergency, the grievance is investigated and, if valid, resolved within a reasonable time at the lowest level possible, valid emergencies receive immediate attention, 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 complaint, the facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse, to prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer, or other facility staff, family members, or legal representatives. The facility shall issue a decision in regard to sexual abuse within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. The facility will send all grievances related to sexual abuse and the facilit"s decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process." In an interview with the GO, it was indicated a detainee could file a formal grievance at any time and in lieu of lodging an informal grievance or compliant and no time limit would be imposed. Interviews with three random DOs confirmed a medical emergency associated with a sexual assault would be referred to medical immediately. In addition, interviews with three random DOs confirmed detainees could utilize the assistance of staff, another detainee, family members or legal representatives. During the onsite audit the Auditor was able to test submission of a grievance through the tablet. The facility did receive the grievance and responded within 24 hours. There were no sexual abuse allegations reported through the grievance system during the audit period.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigations and the prosecution of sexual abuse and assault perpetrators to most appropriately address their needs. The facility has entered into memoranda of understanding or other agreement with community service providers or, if local providers are not available, national organization that provide legal advocacy and confidential emotional support services for immigrant victims of crime. The facility administrator has established procedures to make available to detainees' information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If no such local organization exist, the facility makes available the same information about national organizations. Following an allegation of sexual abuse, the facility administrator has established procedures to make available, to the full extent possible, additional outside victim services. The facility does attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available, the facility works with ICE/ERO to provide these services from a qualified staff member from a community-based organization, or a qualified staff member. The victim advocate shall be able to provide emotional support, crisis intervention, information, and referrals. The facility enables reasonable communication between detainees and these organizations or agencies, in as confidential a manner as possible. Staff shall 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." Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource as crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide valuable expertise and support during an investigation and the prosecution of sexual abuse and assault perpetrators. In addition, interviews could not confirm that Compass Health would provide legal advocacy and confidential emotional support services for immigrant victims of crime. During the onsite audit, the mental health professional from Compass Health came to the facility; however, excited before the Auditor could conduct an interview. The Auditor attempted to contact the mental health professional from Compass Health via telephone; however, calls have not been returned. During the onsite audit the Auditor did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse or a disclaimer that informed detainees prior to access with a local organization 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.

Does Not Meet (a)(c)(d): The facility is not in compliance with subsections (a), (c) and (d) of this standard. Interviews with the PSA Compliance Manager and nurse confirmed that a mental health professional from Compass Health comes into the facility every Wednesday and detainees could utilize this resource as crisis intervention, counseling, information, and referrals if needed; however, interviews could not confirm that Compass Health would provide valuable expertise and support during an investigation and the prosecution of sexual abuse and assault perpetrators. In addition, interviews could not confirm that Compass Health would provide legal advocacy and confidential emotional support services for immigrant victims of crime. During the onsite audit, the mental health professional from Compass Health came to the facility; however, excited before the Auditor could conduct an interview. In addition, the Auditor did not observe the name of a local organization that can assist detainees who have been victims of sexual abuse or a disclaimer that informed detainees prior to access with a local organization 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. In an interview with the PSA Compliance Manager, it could not be confirmed the facility has attempted to enter an MOU with a community resource to provide support in the areas of crisis intervention, counseling, investigation, and prosecution of sexual abuse perpetrators to address victims' needs most appropriately. To become compliant, the facility must submit documentation to confirm LCDC has attempted to enter into an MOU with an outside community service provider, or national organization, to provide valuable expertise and support during an investigation and the prosecution of sexual abuse and assault perpetrators and legal advocacy and confidential emotional support services for immigrant victims of crime. In addition, the facility must make available to all detainees the contact information to a local entity, or national organization, that can provide legal advocacy and confidential emotional support services for detainee victims of sexual abuse and must inform detainees in a manner all detainees can understand, prior to giving them access to any outside resource, the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

§115.54 - Third-party reporting.

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

Notes:

LCDC policy SAAPI mandates, "The facility has established a method to receive third-party reports of sexual abuse in its facility and makes available to the public information on how to report sexual abuse on behalf of a detainee." The Auditor reviewed the facility website, https://lcsomo.gov/jaildivision/ and confirmed it does not include information for the public to make a third-party report of sexual abuse on behalf of a detainee; however, during the onsite audit the Auditor observed reporting information for the public within the waiting area of the facility.

Recommendation: The Auditor recommends the facility post information on how the public can make a third-party report on behalf of a detainee on the facility website.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c)(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 mandates, "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." LCDC policy SAAPI mandates, "The facility requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse and assault 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. Staff must also be able to report the above outside of the chain of command. 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 reports that information to the FOD so ICE can report the allegation to the designated State or local services agency under applicable mandatory reporting laws" In interviews with three random DOs it was confirmed they were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation or staff neglect that may have contributed to the abuse and that they could make a report of sexual abuse outside the chain of command. In addition, in interviews with three random DOs it was indicated they would not reveal any information regarding an allegation of sexual abuse to anyone other than to the extent necessary on a need-to-know basis. In an interview with the Investigator, it was confirmed that if a detainee victim was under 18 or considered a vulnerable adult under state law, he would report the allegation to ICE and the designated State or local services agency. The facility does not house juveniles. There have been no allegations of sexual abuse that included a vulnerable adult during the audit period.

§115.62 - Protection duties.

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

Notes:

LCDC policy SAAPI mandates, "All staff (employees, volunteers, and contractors) are responsible for being alert to signs of potential sexual abuse or assault, and to situations in which sexual abuses or assaults might occur. If a facility staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the

detainee." Interviews with the JA, PSA Compliance Manager, two SSgts., and three random DOs confirmed should staff become aware of any substantial risk of imminent sexual abuse the detainee would be removed from the situation immediately.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "Upon receiving an allegation that a detainee was sexually abused or assaulted while confined at another facility, the facility administrator shall notify ICE/ERO and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The facility administrator shall notify the detainee in advance of such reporting. The facility documents 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 ICE/ERO (this notification must go directly to the FOD)." Interviews with the JA and PSA Compliance Manager confirmed that should LCDC receive information that a detainee was sexually abused while housed at another facility notifications would be made to the facility where the abuse occurred and the ICE FOD within 72 hours. In addition, interviews with the JA and PSA Compliance Manager confirmed should a detainee be transferred and LCDC be notified of an allegation that happened at their facility, the FOD would be notified by email, and an investigation would be initiated immediately. There were no occurrences where a detainee, transferred from another facility, reported an incident of sexual abuse or where a detainee from LCDC reported that he/she was sexually abused while at LCDC to another facility or where a detainee, transferred from another facility, reported an incident of sexual abuse to the staff at LCDC.

§115.64 - Responder duties.

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

Notes:

(a)(b): LCDC policy SAAPI mandates, "Staff shall take immediate action to separate any detainee who alleges that he/she has been sexually abused or assaulted for the alleged assailant and shall refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms." LCDC policy SAPPI further mandates, "The first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder shall: 1) request the victim not to take any actions that could destroy evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and 2) ensure 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. If the first staff responder is not a security staff member, the responder shall request the alleged victim not take any actions that could destroy physical evidence and then notify security staff." Interviews with three random DOs confirmed all elements of subsection (a) would be followed to include: separation, preservation, and protection of the crime scene, requesting the victim to not take actions to destroy evidence, and ensuring the alleged abuser not take actions to destroy evidence.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "The facility must use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which 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." LCDC policy SAPPI further mandates, "If a victim is transferred between detention facilities, the sending facility, as permitted by law, informs the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility). If the receiving facility is unknown to the sending facility, the sending facility notifies the ICE/ERO, so he or she can notify the receiving facility. Where an alleged victim of sexual abuse or assault that occurred elsewhere in ICE/ERO custody is subsequently transferred to the detention facility, the facility complies with all responses and intervention requirements outlined by this policy, as appropriate based on the nature and status of the case. If any of these requirements cannot be met, the facility will consult with the ICE Field Office Director to determine if ICE/ERO can provide additional assistance." A review of LCDC policy SAAPI, also serving as the facility coordinated response plan, confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership. In addition, a review of LCDC policy SAAPI confirms it states, "if a victim is transferred between detention facilities, the sending facility, as permitted by law, informs the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility)" the standard requires if a victim is transferred to a facility covered by subparts (a) and (b) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services unless the victim requests otherwise. In an interview with the JA it was confirmed should a detainee be transferred to a DHS facility the PSA Compliance Manager would inform the receiving facility of the incident and victim's potential need for medical or social services and should a detainee be transferred to a non-DHS facility the facility would inform the receiving facility of the incident and the victim's potential need for medical or social services, as permitted by law, and only at the request of the detainee: however, the standard requires if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard the sending

facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services unless the victim requests otherwise.

Does Not Meet (a)(c)(d): The facility is not in compliance with subsections (a), (c), and (d) of the standard. A review of LCDC policy SAAPI, also serving as the facility coordinated response plan, confirms it does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership. In addition, a review of LCDC policy SAAPI confirms it states, "if a victim is transferred between detention facilities, the sending facility, as permitted by law, informs the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility)" the standard requires if a victim is transferred to a facility covered by subparts (a) and (b) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services unless the victim requests otherwise. To become compliant, the facility must update LCDC policy SAAPI to include the coordinated actions to be taken staff first responders, medical and mental health practitioners, investigators, and facility leadership. In addition, the facility must updated LCDC policy SAAPI to include the verbiage "if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the 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 and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise." Once updated the facility must submit documentation that confirms all applicable staff, including medical personnel, have been trained on the requirement of subsection (d) of the standard that states, "If a victim of sexual abuse is transferred to a non-DHS Facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victi"s potential need for medical or social services, unless the victim requests otherwise." If applicable, the facility must provide the Auditor with any sexual abuse investigation files, and corresponding medical and mental health records, of a detainee who was transferred due to an incident of sexual abuse to a facility not covered by paragraph (c) of the standard to confirm compliance with subsection (d) of the standard.

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

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

Notes:

LCDC policy SAAPI mandates, "Staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." In an interview with the JA, it was confirmed security staff would be placed on administrative leave with or without pay and contractors suspected of perpetrating sexual abuse would have their security clearance suspended pending the outcome of an investigation. There are no volunteers at LCDC who provide services for detainees during the audit period. There were no reported allegations of sexual abuse at LCDC during the audit period.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): LCDC policy SAPPI mandates, "Staff, contractors, and volunteers 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. The facility employs 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 or assault, the facility, in concert with ICE/ERO, monitors to see if there are facts that may suggest possible retaliation by detainees or staff, and facility monitors 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 by staff. The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The Auditor reviewed the Sexual Assault Evaluation form and confirmed it requires that the detainee is reviewed after 30-60-90-days and not beginning at the time the allegation is made. Interviews with the JA and PSA Compliance Manager confirmed that the facility does not monitor staff for retaliation following an incident of sexual abuse.

Does Not Meet (b)(c): The facility is not in compliance with subsection (b) and (c) of this standard. The Auditor reviewed the Sexual Assault Status Evaluation form and confirmed it includes 30-60-90-day assessment blocks and does not require monitoring to begin immediately following a report of sexual abuse. In addition, in interviews with the JA and PSA Compliance Manager it was confirmed monitoring following a report of sexual abuse does not include staff members. To become compliant, the facility must implement a practice that requires monitoring of retaliation to begin immediately following a report of sexual abuse and not 30 days after the report is made. In addition, the facility must implement a practice that includes monitoring of staff involved in making the report. The facility must train all applicable staff involved in the monitoring of detainee victims of sexual abuse in the new practice and document such training. The facility must also provide the Auditor with copies of all sexual abuse allegation investigation files and corresponding monitoring documentation that occur during the CAP period to confirm compliance with the standard.

§115.68 - Post-allegation protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): LCDC policy SAAPI mandates, "Victims and vulnerable detainees shall be housed in a supportive environment that represents the least restrictive housing option possible (e.g. in a different housing unit, transfer to another facility, medical housing, or protective custody), and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical or mental health needs of the victim. Placement of administrative segregation should be the last resort when no other housing options exist. Victims may not be held for longer than five days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim. The facility notified the appropriate ICE/ERO FOD whenever a detainee victim, or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hours. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault." In interviews with the JA and PSA Compliance Manager it was indicated detainees would be held in administrative segregation for the least amount of time, that placement would not exceed five days except in highly unusable circumstances or at the request of the detainee, and notification would be immediately made to the ICE FOD, via a phone call, should a detainee be held in administrative segregation for 72 hours. In an interview with the PSA Compliance Manager, it was confirmed detainees placed into protective custody after being subjected to sexual abuse would not be reassessed prior to their return to general population to consider any increased vulnerability of the detainee as a result of the sexual abuse. There were no detainees placed in protective custody at LCDC due to an allegation of sexual abuse during the audit period.

Does Not Meet (c): The facility is not in compliance with subsections (c) of the standard. In an interview with the PSA Compliance Manager, it was confirmed detainees placed into protective custody after being subjected to sexual abuse would not be reassessed prior to their return to general population to consider any increased vulnerability of the detainee as a result of the sexual abuse. To become compliant, the facility must develop a practice that includes a proper reassessment of all detainees placed in protective custody after being subjected to sexual abuse prior to release to general population to consider any increased vulnerability of the detainee as a result of the sexual abuse. Once implemented, the facility must submit documented training of all applicable staff on the updated practice. If applicable, the facility must submit any allegation of sexual abuse investigations that include the detainee being placed in protective custody due to an allegation of sexual abuse, and the corresponding detainee's detention file, that occur during the CAP to confirm the new practice has been implemented.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f): LCDC policy SAAPI mandates, "All investigations must be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators. 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 reviews any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. The ICE Office of Professional Responsibility will typically be the appropriate investigative office with DHS, as well as the DHS OIG in cases where the DHS OIG is conducting an investigation. The facility has written procedures for administrative investigations, including provisions requiring: 1) preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; 2) interviewing alleged victims, suspected perpetrators, and witnesses; 3) reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; 4) 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 a detainee who alleged sexual abuse or assault to submit to a polygraph; 5) an effort to determine whether actions or failures to act at the facility contributed to the abuse; 6) 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; 7) retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years; and 8) coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." LCDC policy SAPPI further mandates, "The departure of the alleged abuser or victim from the employment or control of the facility does not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse and assault, the facility does cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Where an alleged victim of sexual abuse or assault that occurred elsewhere in ICE/ERO custody is subsequently transferred to the facility, the does also cooperate with any administrative or criminal investigative efforts arising from the incident. Following an investigation conducted by the facility into a detainee's allegation of sexual abuse, the facility notifies ICE/ERO of the results of the investigation and any responsive actions taken so that the information can be reported to ICE/ERO headquarters and to the detainee." A review of LCDC policy SAAPI confirms the facility shall develop written procedures to include all provisions of subsection (c) of the standard; however, the facility has not submitted to the Auditor the facility's developed written procedures. In an interview with the Investigator, it was confirmed that he would conduct investigations in a prompt, thorough and objective manner. The Auditor was provided with his certificate of completion from the National Institute of Corrections for the course: PREA: Investigating Sexual Abuse in a Confinement Setting. The Auditor reviewed the training curriculum and confirmed it included all elements required by the standard. In interviews with the JA, PSA Compliance Manager, and Investigator it was confirmed an administrative investigation would

be completed upon a substantiated finding of sexual abuse resulting from a criminal investigation and if the finding was unsubstantiated, it would be reviewed to ascertain if an administrative investigation was warranted. Interviews with the JA and PSA Compliance Manager confirmed that DHS would be consulted pending an administrative investigation. In interviews with the JA and Investigator, it was confirmed the departure of the alleged victim or perpetrator from the employment or control of the facility or agency would not provide a basis for terminating an investigation. In an interview with the investigator, it was confirmed all criminal investigations would be conducted by the LCSO unless there is a conflict of interest that would require the investigation be referred to the MSP. During the onsite audit, the Auditor interviewed a representative from MSP and confirmed they would investigate the incident per Missouri Statue and the facility would remain informed of the investigations progress through telephone calls or emails. There were no allegations of sexual abuse reported at the facility during the audit period.

Does Not Meet (a)(b)(c)(e)(f): The facility is not in compliance with subsections (a), (b), (c), (e), and (f) of this standard. The facility has not established the required written procedures for conducting administrative investigations. As the facility does not have a written protocol, the requirements of subsections (a), (b), (c), (e), and (f) that must be included in the protocol are also non-compliant. To become compliant, the facility must develop a written protocol that includes all elements of subsections (a), (b), (c), (e), and (f) of the standard. In addition, the facility must submit document that all applicable staff have been trained on the protocol's content. If applicable, the facility must provide the Auditor with copies of all sexual abuse allegation investigation files that occurred during the CAP period.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Agency Policy 11062.2 mandates, "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." LCDC policy SAAPI mandates, "The facility uses no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated." In an interview with the Investigator, it was confirmed that no standard higher than a preponderance of the evidence would be used to determine whether allegations of sexual abuse are substantiated. There were no allegations of sexual abuse reported during the audit period.

§115.73 - Reporting to detainees.

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

Notes:

(a): Agency Policy 11062.2 mandates, "For detainees still in ICE immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation of sexual abuse or assault, notify the detainee as to the result of the investigation and any responsive action taken, in coordination with the FOD." LCDC policy SAAPI mandates, "Following an investigation conducted by the facility into a detainee's allegation of sexual abuse, the facility notifies ICE/ERO of the results of the investigation and any responsive actions taken so that the information can be reported to ICE/ERO headquarters and to the detainee." In an interview with the JA, it was confirmed that after an investigation was completed notification would be made to ICE/ERO who would then notify the detainee of the outcome, and any responsive action taken. There were no allegations of sexual abuse reported at LCDC during the audit period.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d): LCDC policy SAPPI mandates, "Staff shall be subject to disciplinary or adverse action, up to and including removal from their position, for substantiated allegations of sexual abuse or assault or for violating ICE/ERO or facility sexual abuse rules, policies or standards. Removal from their position is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse, as defined under the definitions or staff-on-detainee abuse in the definition section of policy. The facility reports all incidents of substantiated sexual abuse by staff, and all removals of staff or resignations in lieu of removal for violations of sexual abuse policies, to appropriate law enforcement agencies unless the activity was clearly not criminal. The facility reports all such incidents of substantiated abuse, removals, or resignations in lieu of removal to ICE/ERO, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known." A review of LCDC policy SAAPI confirms it does not contain the verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" or "removal from 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." However, as termination is greater than removal from Federal Service, the Auditor finds LCDC SAAPI in substantial compliance with the wording required by subsection (b) of the standard. In an interview with the JA, it was confirmed that staff would be subject to disciplinary or adverse action including termination for substantiated allegations of sexual abuse and that the appropriate notifications would be made to any law enforcement or relevant licensing bodies as required. To document compliance the Auditor was provided a blank template of a termination notice and an example transmission to the licensing body for detention staff. In an interview with the SDDO it was confirmed LCDC policy SAAPI was reviewed and approved by the Agency. There were no allegations of sexual abuse reported at LCDC during the audit period.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility takes appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractor or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility reports such incidents to the ICE/ERO regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." In an interview with the JA, it was confirmed any contractor who has engaged in sexual abuse will be prohibited from any detainee contact, have their security clearance revoked, and would not be able to enter the facility until the investigation was completed. In addition, the JA confirmed that any contractor who engages in sexual abuse would be reported immediately to the LCSO and any relevant licensing bodies. To document compliance the Auditor was provided a blank template of a termination notice that would be utilized if needed. There were no volunteers who provided services to detainees at LCDC during the audit period. There were no allegations of sexual abuse reported at LCDC during the audit period.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f): LCDC policy SAAPI mandates, "Detainees shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault. The facility does 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 disciplinary action, a report of sexual abuse or assault made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. If a detainee is mentally disabled or mentally ill but competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanctions, if any, should be imposed." The Auditor reviewed the submitted LCDC prohibited acts and associated penalty for each act and confirmed rule 1.4 Engaging in Sexual Acts is a Class 1 violation. Class 1 violations are the most severe actions in the disciplinary process. The facility provided the Auditor with a "Disciplinary Tracking Sheet/Disciplinary Segregation Order" form. The form is utilized to document the rule violation, sanction imposed, additional blocks for information should a detainee be placed into a lockdown status, date and time of disciplinary hearing and signature lines for staff and detainee. At the bottom of the form is a statement that lets the detainee know the decision can be appealed through the grievance process. In an interview with the JA, it was confirmed a detainee's mental disability or illness would be considered in determining sanctions, a detainee would not be disciplined for sexual contact with a staff member unless the contact was coerced, and reports made in good faith and later found to have insufficient evidence to substantiate the investigation would not constitute falsely reporting an incident or lying. Interviews with the JA, PSA Compliance Manager, and two SSgts. confirmed the disciplinary process is progressive with increasing penalties and several layers of appeals. There were no allegations of sexual abuse reported at LCDC during the audit period.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "If screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation, no later than two working days from the date of the assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming; and therefore, the initial risk assessment does not adequately indicate if a detainee has experienced prior sexual victimization or perpetrated sexual abuse. In an interview with the nurse, it was indicated medical evaluations would be completed on the next working day; however, the mental health professional is only at the facility one day a week; and therefore, should a mental health referral be initiated the facility cannot confirm the evaluation would be conducted within 72 hours of the referral as required by the standard.

Does Not Meet (a)(c): The facility is not in compliance with subsection (a) and (c) of this standard. The Auditor reviewed the provided RCA completed by ICE and confirmed the RCA screening does not take into consideration whether the detainee has prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, or whether the detainee identifies as lesbian, gay, bi-sexual, intersex, or gender nonconforming; and therefore, the initial risk assessment does not adequately indicate if a detainee has experienced prior sexual victimization or perpetrated sexual abuse. In addition, in an interview with the nurse it was confirmed the mental health professional is only at the facility one day a week; and therefore, should a mental health referral be initiated the facility cannot confirm the evaluation would be conducted within 72 hours of the referral as required by the standard. To become compliant, the facility must develop and implement a procedure that requires the facility to adequately access all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims. In addition, the facility must implement a practice that requires all detainees referred to mental health be seen within 72 hours as required by subsection (c) of the standard. Once implemented the

facility must submit documentation that all applicable staff, including intake, and medical, and mental health have received training on the new procedure. If applicable, the facility must submit to the Auditor all intake, medical, and mental health records of any detainee, who during the CAP period, indicates pursuant to standard §115.41 they have experienced prior sexual victimization or perpetrated sexual abuse.

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

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

Notes:

(a)(b): LCDC policy SAAPI mandates, "Detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." In an interview with the nurse, it was indicated that detainees would be transported to Lincoln Mercy Hospital for emergency treatment as needed. The nurse also confirmed that treatment would be provided free of charge to the detainee. Detainee treatment plans would continue at the facility with follow up care provided by a doctor as needed. During the onsite audit, the Auditor contacted an emergency room nurse at Lincoln Mercy Hospital and confirmed emergency treatment and crisis intervention services would be provided in accordance with professionally accepted standard of care to include emergency contraception and sexually transmitted infections prophylaxis regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f)(g): LCDC policy SAAPI mandates, "The facility offers medical and mental health evaluations and, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. The facility attempts 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. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility provides such victims with medical and mental health services consistent with the community level of care." In an interview with the facility nurse, it was indicated detainees victimized by sexual abuse would receive a medical and mental health evaluation and, as appropriate, treatment; however, the nurse could not articulate what treatment would be offered. In addition, the nurse could not confirm that the facility would attempt to conduct a mental health evaluation of all known-detainee-on-detainee abusers. During the onsite audit, the Auditor contacted an emergency room nurse at Lincoln Mercy Hospital and confirmed medical treatment would be provided consistent with the community level of care to include pregnancy tests, timely and comprehensive information about lawful pregnancy related medical services, needed lawful pregnancy related medical services, and tests for sexually transmitted infections without financial cost and regardless of whether the victim names the abuser. However, the emergency nurse could not confirm that the detainee would be offered a mental health evaluation or treatment consistent with community care, if appropriate. There was no allegation of sexual abuse reported at LCDC during the audit period.

Does Not Meet (a)(b)(c)(f)(g): The facility is not in compliance with subsections (a), (b), (c), (f), and (g) of the standard. In an interview with the facility nurse, it was indicated detainees victimized by sexual abuse would receive a medical and mental health evaluation and, as appropriate, treatment; however, the nurse could not articulate what treatment would be offered. In addition, the nurse could not confirm that the facility would attempt to conduct a mental health evaluation of all known-detainee-on-detainee abusers. During the onsite audit the Auditor contacted an emergency room nurse at Lincoln Mercy Hospital and confirmed medical treatment would be provided consistent with the community level of care to include pregnancy tests, timely and comprehensive information about lawful pregnancy related medical services, needed lawful pregnancy related services, and tests for sexually transmitted infections without financial cost and regardless of whether the victim names the abuser. However, the emergency nurse could not confirm that the detainee would be offered a mental health evaluation or treatment consistent with community care, if appropriate. To become compliant the facility must provide documentation that confirms mental health staff are available to provide the detainee victim of sexual abuse with all required elements of subsections (a), (b), (c), (f), and (g) of the standard. If applicable, the facility must provide the Auditor with any sexual abuse allegation investigative files that occurred during the CAP period. If applicable, the facility must provide the detainee files, including medical and mental health, of any known detainee-on-detainee abusers housed at LCDC during the CAP period.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): LCDC policy SAAPI mandates, "The facility conducts a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For a substantiated or unsubstantiated allegation, the facility prepares 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 and assault. Unfounded allegation means an allegation was investigated and determined not to have occurred. The facility does implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and the response shall be forwarded to ICE/ERO for transmission to the ICE/ERO PSA Coordinator. The facility provides any further information regarding such incident reviews as requested by the ICE/ERO PSA Coordinator. The 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 facility will conduct an annual review of all sexual abuse and assault investigations and resulting incident reviews to assess and improve sexual abuse and assault intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse and assault during the annual reporting period, then the facility will prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and ICE/ERO for transmission to the ICE PSA Coordinator (this notification must be sent directly to the FOD)." In Interviews with the JA and PSA Compliance Manager, it was confirmed the facility does not prepare a negative report in the absence of reported allegations during the year. There were no allegations of sexual abuse reported at LCDC during the audit period.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. Interviews with the JA and PSA Compliance Manager, it was confirmed the facility does not prepare a negative report in the absence of reported allegations during the year. To become compliant, the facility must submit documentation to the Auditor that a negative PREA report was completed for the year 2022 and forwarded to the facility administrator, the FOD or designee, and the Agency PSA Coordinator.

§115.87 - Data collection.

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

Notes:

(a): LCDC policy SAPPI mandates, "The facility maintains, in a secure area, all case records associated with claims of sexual abuse and assault, 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 shall be maintained in appropriate files in accordance with these detention standards an applicable policies, and retained in accordance with established schedules." In an interview with the PSA Compliance Manager, it was confirmed the JA would maintain case records in a secured file cabinet in his office. During the on-site audit, the Auditor observed the storage of records and determined the facility complies with the standard.

§115.201 - Scope of audits.

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

Notes:

(d)(e)(i)(j): The Auditor was able to observe all areas of the audited facility. All policies, memorandums, staff files, records and other relevant documentation was provided for review to complete a thorough audit. Audit notices were posted and observed throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor received no staff or detainee, or other party correspondence.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	18
Number of standards not met:	21
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Jodi Upshaw 6/13/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 6/13/2023

anager's Signature & Date

(b) (6), (b) (7)(C)

6/14/2023

Program Manager's Signature & Date