PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

Not at AUDIT DATES			
From:	8/10/2021	**To:**	8/12/2021
AUDITOR INFORMATION			
Name of auditor:	Sharon R. Shaver	**Organization:**	Creative Corrections
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Dallas
Field Office Director:	Mark Moore
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C) SDDO
Field Office HQ physical address:	8101 N. Stemmons Frwy, Dallas, TX
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Okmulgee County Criminal Justice Authority – Moore Detention Facility		
Physical address:	111 S. Alabama Ave, Okmulgee, OK		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	918-938-0725		
Facility type:	IGSA		
PREA Incorporation Date:	8/20/2018		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director of Operations
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	918-520-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Coordinator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	918-650-

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the Okmulgee County Criminal Justice Authority – Moore Detention Facility, a.k.a. Okmulgee County Jail (OCCJA-MDF) was conducted August 10-12, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor Sharon Shaver, employed by Creative Corrections, LLC. This is the first DHS Immigration Customs Enforcement (ICE) PREA audit of the facility. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, [redacted], and Assistant ICE Program Manager, (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The audit period is the previous 12 months, August 2020 through August 12, 2021.

On July 19, 2021, ICE/OPR/ERAU Inspections and Compliance Specialist (ICS) Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. All documentation, policies, and the PAQ were reviewed by the Auditor. The Auditor requested and received additional documentation from the ERAU Team Lead and facility staff prior to the audit's on-site audit. The on-site audit began with communications between the Auditor and the Team Lead to determine logistics and to set a schedule for the on-site visit of OCCJA-MDF. The Auditor requested that the facility have printed and available on the first day of the on-site visit a current detainee roster, a copy of the facility detainee handbook, a list of detainees identifying as transgender, and a list of detainees who are identified as limited English proficient (LEP). The Auditors arrived at the facility and entered with the Team Lead and ICE/OPR/ERAU ICS (b) (6), (b) (7)(C) at 8:00 a.m. on Tuesday, August 10, 2021. During the in-briefing introductions were made and then the Auditor provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge and practice of staff at all levels.

In attendance were:

- (b) (6), (b) (7)(C) Director of Operations, OCCJA
- (b) (6), (b) (7)(C) Compliance & Accreditation Manager/Prevention of Sexual Abuse (PSA) Compliance Manager, OCCJA
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE
- (b) (6), (b) (7)(C) ICS, ICE
- (b) (6), (b) (7)(C) ICS, ICE
- Sharon R. Shaver, Certified DOJ/DHS Auditor, Creative Corrections, LLC

After the in-briefing, the Auditor was taken on a tour of the facility by the PSA Compliance Manager. The facility advised that detainees housed on one unit were under quarantined since they had just arrived, and the facility's protocols are to keep new arrivals separate for ten days and if they develop no symptoms, they can be placed in general population. All areas of the facility were toured, to include the quarantined unit since they were confined to their cells and not out in the common area. The facility consists of one building with two floors. The second floor houses the administrative offices and a central control, where all living units can be observed from an octagon shaped room with windows. The first floor includes four living units, segregation unit, medical section, kitchen, intake, visitation, and additional administrative offices and conference room. ICE detainees are housed in Dorms W, Y, and Z. Dorm X is dedicated to the Marshall's Service which are not audited within the scope of this audit. The living units, recreation yard, and kitchen are accessible directly from the rotunda; intake, medical and segregation are connected to the rotunda through the East hallway; and the administrative offices and visitation area are connected to the rotunda through the West hallway. The design capacity of the facility is 246. Dorm W is open dormitory style and has 2 levels, with bathroom fixtures on the top and bottom levels; this living unit houses high-security detainees and has 12 beds on the top range and 12 beds on the lower range for a total of 24 beds. Dorm Y is dormitory style, with a single level and houses up to 30 medium-security detainees. Dorm Z has 13 cells on the lower range and 14 cells on the upper range, with 2 beds each for a total of 54. There are 22 segregation beds and 2 medical unit beds. The segregation cells are two-bunk cells and are equipped with in-cell showers with a curtain. The intake area is small and will not accommodate processing more than one detainee at a time. When intake is larger than a few detainees, Dorm Z is used as a staging area for processing incoming detainees. There were no new arrivals received during the on-site visit, so the intake staff provided a simulation of the intake process for the Auditor. In addition, the Auditor reviewed video footage from two separate recent intake days. Even though there was no sound available, it allowed the Auditor to observe the movement and proximity of the detainees during the process.

On the first day of the on-site visit there were 119 detainees. The average detainee population for the prior year was reported as 126. The facility reports there were 731 detainees booked into the facility in the audit period. The average time in custody was reported as 20 days. The top three nationalities of the detainee population at the time of the on-site visit were Mexican, Indian, and Asian.

The total number of staff who may have recurring contact with detainees is 105. There are 63 security staff, including ICE employees and contractors. The facility's medical staff is composed of OCCJA staff (13) and utilizes contractors for X-Ray services and mental health services. The facility allows volunteers who provide chaplaincy services for the detainees. The facility operates two 12-hour shifts: 8:00 a.m.-8:00 p.m. and 8:00 p.m. to 08:00 a.m.

After the facility tour, the Auditor met with the PSA Compliance Manager to obtain general facility information, review tour observations, discuss staff and detainee interviews, and to conduct her interview. During the remainder of the on-site visit, the Auditor observed a simulation of the intake and screening processes (no new intakes arrived during the on-site visit), tested the telephone system, reviewed detainee records, reviewed employee training records and personnel records, and reviewed a sampling of other documentation that will be discussed within each standard narrative. As mentioned above, there were 119 detainees present on day one, with 41 quarantined, which left 78 detainees to select from for interviews. The Auditor selected 26 detainees to interview, and 6 were released before the interviews began, leaving a total of 20 detainees interviewed, 13 were LEP detainees. A total of 24 staff were interviewed using random and specialized staff interview protocols.

The Auditor learned that the Director of Operations runs the facility but is not the Warden. The OCCJA has an Executive Director and a Deputy Executive Director to whom the Director of Operations reports. The Auditor asked to interview the Executive Director but was unable to get on his calendar for an interview prior to the close out. The organizational chart provided is for the Okmulgee County Criminal Justice Authority, which encompasses a much larger scope than the Moore Facility, which is the subject of this audit. However, it is important to mention that there are two

separate facilities operated under the Authority, Moore Facility, and the Okmulgee County Unit. The Authority's Director of Operations runs both facilities and staff is shared between the two. There are dedicated employees that are assigned to the Moore Facility, but staff shortages may be augmented by staff from the other facility. Also, the shift supervisors are responsible for providing supervision to both facilities during their individual tours of duty. This will be relevant to the discussion in 115.13.

The facility has 76 video cameras used for electronic monitoring. (b) (7)(E) [redacted] There are no cameras in the laundry room which is directly off the medical area and only used under direct staff supervision. The facility reported that all cameras were operational at the time of the audit. The video camera system was installed in 2017, operates 24 hours per day, 7 days per week, does not record sound, and has the capability to pan, tilt, and zoom. The PSA Compliance Manager provided the Auditor with a tour of the camera system to sample the system's capabilities. The footage is stored on a server for up to 30 days.

There were two detainee-on-detainee allegations reported within the audit period. Neither allegation was investigated at the facility level by an investigator with specialized training; both allegations were completed by a detective from the OCCJA Law Enforcement Division. The allegation outcomes were one unfounded and one unsubstantiated. The OCCJA has its own Law Enforcement Division which is the legal entity to conduct investigations. Recent reorganization of the OCCJA includes delegation of the administrative investigations to the Law Enforcement Division as well as criminal investigations according to the interview with the Director of Law Enforcement. The Law Enforcement Division is not within the scope of this audit based on them being a separate entity reporting directly to the OCCJA, and not to the Moore Facility.

The out-briefing was held at 1:30 p.m., on August 12, 2021, in the conference room, during which the Auditor spoke briefly about her observations. The Auditor informed those present of the preliminary findings and explained the audit report process and timeframes. The Auditor expressed her appreciation for the hospitality and cooperation shown by all staff present during the on-site visit. The following personnel were present:

- (b) (6), (b) (7)(C) Executive Director, OCCJA
- (b) (6), (b) (7)(C) Deputy Executive Director, OCCJA
- (b) (6), (b) (7)(C) Director of Operations, OCCJA
- (b) (6), (b) (7)(C) Director of Law Enforcement, OCCJA
- (b) (6), (b) (7)(C) Compliance & Accreditation Manager/PSA Compliance Manager, OCCJA
- (b) (6), (b) (7)(C) Chaplin, OCCJA
- (b) (6), (b) (7)(C) SDDO, ICE
- (b) (6), (b) (7)(C) Contracting Officer Representative (COR), ICE
- (b) (6), (b) (7)(C) ICS/ICE
- (b) (6), (b) (7)(C) ICS/ICE
- Sharon R. Shaver, Certified DOJ/DHS Auditor, Creative Corrections, LLC

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2

§115.31 Staff training
§115.32 Other training

Number of Standards Met: 21

§115.11 Zero-tolerance of sexual abuse
§115.13 Detainee supervision and monitoring
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.34 Specialized training: Investigations
§115.42 Use of assessment information
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.66 Protection of detainees from contact with alleged abusers
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 16

§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient (LEP)
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.33 Detainee education
§115.35 Specialized training: Medical and Mental Health care
§115.41 Assessment for risk of victimization and abusiveness
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.71 Criminal and Administrative Investigations
§115.73 Reporting to detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews

Number of Standards Not Applicable: 2

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

PROVISIONS

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

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

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

Notes:

(c): The facility has a written policy, OCCJA 2.10, Prison Rape Elimination Act, that requires OCCJA-MDF to have zero-tolerance towards all forms of sexual abuse and sexual harassment and to establish effective standards, as defined by the Prison Rape Elimination Act of 2003, for preventing, detecting, and responding to such conduct which are outlined within the policy. The facility's Sexual Abuse and Awareness Prevention and Intervention (SAAPI) policy was reviewed and approved by the ICE Assistant Field Office Director (AFOD) on 11/13/2020. The Auditor observed the postings, which were laminated and attached by a chain on the walls, and in other locations throughout the facility which contained the ICE Zero-Tolerance poster, facility handbooks, and the DHS-prescribed Sexual Assault Awareness Information pamphlet to convey the message of the zero-tolerance for sexual abuse and sexual harassment for the facility.

(d): The facility employs an Accreditation & Compliance Manager who is the designated PSA Compliance Manager; this was verified through interviews with the Director of Operations as well as a review of the OCCJA Organizational Chart. The PSA Compliance Manager is the designated local point of contact for the ICE PSA Coordinator. The PSA Compliance Manager indicated during her interview that she has sufficient authority and time to oversee efforts for the facility with the zero-tolerance policy and oversee the facility's efforts to comply with the facility's sexual abuse prevention and intervention policies and procedures. She was recently promoted to this position and is still learning the scope of her responsibilities. The OCCJA Organizational Chart identifies the PSA Compliance Manager as a direct report to the Director of Operations.

§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): Policy OCCJA/2.10 states that "OCCJA will develop, document, and comply on a regular basis with a staffing plan that provides adequate levels of staffing, and where applicable, video monitoring to protect detainees against sexual abuse." The policy further states "each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan." The shift supervisor is responsible for updating their daily rosters throughout the shift to document staff assigned to each area. The Organizational Chart provided includes the full OCCJA structure, which encompasses a much larger scope than the Moore Facility, which was mentioned prior in the introductory narrative. On the OCCJA Organizational Chart, the security staff is under the Detention Division and is comprised of 3-Captains, 6-Sergeants, and 36 Detention Officers who staff both detention facilities under the OCCJA. Based on the written staffing plan provided by the facility, there are 5-Captains, 8-Sergeants, 18-Detention Officers who work at Moore Facility. In response to the Auditor's inquiry about the staffing differences between the numbers listed on the OCCJA Organizational Chart and the Staffing Plan, it was explained by the Director of Operations the additional staff listed on the Staffing Plan are identified on the OCCJA Organizational Chart under different divisions but are trained and cleared to work with ICE detainees. He also explained that all detention officers are trained to work both facilities and staff from the other facility frequently work the Moore Facility to cover for any staff shortages. As part of normal operations, the captains (shift supervisors) supervise both facilities simultaneously. The sergeants are responsible for preparing the daily roster and making post assignments. The Director of Operations explained during his interview that the facility attempts to maintain a minimum of three detention officers per shift which supports one in Central Control Room and two on the floor. The shift commander interviewed confirmed that three detention officers is the minimum required per shift to operate the facility and that she can always pull assistance from the other facility if needed. There is a detention officer in the central control room 24 hours per day, who will monitor security and surveillance equipment. The officer can see directly into the housing units from the central control based on the design of the structure. (b) (7)(E) monitoring. (b) (7)(E) There are no cameras in the laundry room which is directly off the medical area and only used under direct staff supervision. The facility reported that all cameras were operational at the time of the audit. The video camera system was installed in 2017, operates 24 hours per day, 7 days per week, does not record sound, and has the capability to pan, tilt, and zoom. The PSA Compliance Manager provided the Auditor with a tour of the camera system to sample the system's capabilities. The footage is stored on a server for up to 30 days.

Recommendation: The Auditor observed low lighting in some of the cells in RHU/SMU which was determined to be due to detainees putting paper and other obstructions over the fixtures. The Auditor recommended to have the obstructions removed and that this issue be monitored more closely and addressed in future/on-going supervision practices. These cells are two-bunk cells and are equipped with in-cell showers with a curtain. Proper lighting is necessary for staff to make cell checks and to monitor detainee behavior and activity.

Recommendation: Policy OCCJA/2.10 states "The shift supervisor will update their post orders throughout the shift to document staffing assigned to each area." The Auditor recommends making a policy edit to change "update their post orders" to "update their post assignments or daily roster," or similar language.

(b)(c): The comprehensive detainee supervision guidelines are documented through Policy OCCJA 2.8, Post Orders. Post Orders provided for the Auditor's review included: General, Medical, Booking, SMU, Central Control, Disciplinary, Housing, Escort, Laundry, Visitation, Sergeant, and Transport. These post orders contain general and specific duties and a delineation of specific responsibilities of the staff in charge of a post. These post orders are approved by the Executive Director, always kept current and formally reviewed at least annually and updated as needed according to Policy OCCJA 2.8.. This policy and subsequent post orders were dated 06/01/2021. Policy OCCJA/2.10 further explains that "at least once every year, the facility, in collaboration with the PREA Coordinator, reviews the staffing plan and data regarding sexual abuse or assault incidents to meet and determine whether adjustment is needed in the staffing plan, the deployment of monitoring technology, or the allocation of agency/facility resources to commit to the staffing plan to ensure compliance. The findings are reported to ICE for use in determining whether changes are needed to existing policies and practices to further the goal of eliminating sexual abuse." The Director of Operations explained during his interview and Policy OCCJA/2.10 establishes that "the facility shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical

layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incidents review reports, and any other relevant factors, including by not limited to the length of time detainees spend in agency custody" in determining adequate levels of detainee supervision and the need for video monitoring. One Sexual Abuse Incident Review was conducted during the audit period and it included no recommendations for detainee supervision as confirmed through interview with the Director of Operations and the Auditor's review of the completed form. The Director of Operations confirmed during his interview that the post orders and staffing plan will be reviewed at least annually, or more often if the need to update becomes necessary.

(d): Policy OCCJA/2.10 requires "supervisors to conduct unannounced supervisor rounds of the facility periodically, but no less than weekly, to identify and deter staff sexual abuse and sexual harassment. Staff is prohibited from alerting other staff members when the supervisor is conducting these unannounced rounds." According to Policy OCCJA 2.8k, Detention Post Orders Sergeant, "At least once per shift, the sergeant will conduct unannounced reviews to deter staff sexual abuse and mistreatment. Staff and employees will not announce the review unless such an announcement is related to legitimate operational functions. Reviews will be conducted, on a random basis, on random pods, including the kitchen and laundry areas. "Unannounced reviews will be documented in the shift supervisor's log noted as PREA unannounced review by 'name of sergeant' and with the date, time, and location." Sergeants interviewed by the Auditor confirmed that they make at least one unannounced round per shift to deter sexual abuse and that these rounds are documented on the supervisor's log. Additional rounds required by officers per the post orders include 15-minute checks of detainees in medical and holding cells and 30-minute checks of detainees in the housing units and SMU. Detention Officers confirmed during their interviews that they make frequent rounds in the housing units, but no less than every 30 minutes. They explained that they document the time of the round with their initials on the door sheets. The Sergeant explained that the door sheets are picked up daily and placed with the supervisor's daily shift packet. The Auditor's review of three daily shift packets and the door sheets during the on-site visit found that frequent checks are made in the housing units and in RHU/SMU. The sergeant's rounds were not documented as unannounced rounds consistently on the daily shift packet as required by the facility's policy. Interviews with detention officers, sergeants, and supervisors confirmed that staff do not alert others of the unannounced rounds. Periodic supervisor rounds were noted on one of the packets as "supervisor welfare check."

Recommendation: The Auditor learned during interviews and review of door sheets that rounds are frequently made, but there is minimal documentation to support that the required "unannounced security inspections to identify and deter sexual abuse of detainees" are being conducted. The Auditor recommends that these rounds be documented consistently, and in accordance with the OCCJA Policies 2.8k and 2.10 which will provide clear documentation that these rounds are occurring.

The Auditor observed and confirmed through interviews that there were no detention officers assigned to specific housing units to monitor detainee activity constantly, and that they are all multi-functional officers who are responsible for making rounds and completing tasks at other posts throughout the facility. During day-time hours there are other staff on-site to support operations and to assist with detainee monitoring and supervision; however, the Auditor has concerns with the facility's ability to provide adequate supervision with three officers between 8:00 p.m. to 8:00 a.m.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The facility does not accept juveniles or family detainees. This was confirmed by memorandum, dated June 23, 2021, submitted with the PAQ and through interviews conducted with the Director of Operations and PSA Compliance Manager. The detainee population roster provided to the Auditor during the on-site visit indicated there were no detainees under the age of 18.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(e): Policy OCCJA/2.10 states "cross-gender pat down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat down search is required or in exigent circumstances." The policy further prohibits "cross-gender strip searches except in exigent circumstances or when performed by a medical doctor." The facility "does not conduct body cavity searches," per policy, and confirmed through interviews. Interviews with all levels of staff and detainees confirmed that only male officers conduct searches of detainees.

(c): Opposite gender searches of female detainees are prohibited by policy, although the facility does not house female detainees. This provision is non-applicable.

(d)(f): Policy OCCJA/2.10 states "all cross-gender strip searches and cross-gender visual body cavity searches shall be documented and all cross-gender pat-down searches of female detainees shall be documented." The policy does not impose a requirement for cross-gender pat-down searches of male detainees to be documented, yet provision (d) requires all cross-gender pat-down searches to be documented. The facility provided a blank form DHS/ICE, G-1025 "Record of Search Form," which would be used in the event an opposite-gender search is conducted. There were no documented opposite gender searches of any kind for the audit period. Staff interviews confirmed that no opposite-gender strip searches or visual body cavity searches have been conducted. Staff interviews indicated staff are unaware that opposite-gender pat searches must be documented.

Does Not Meet (d): The facility does not require cross-gender pat searches of male detainees to be documented. The facility must implement a system for documenting cross-gender pat searches of male detainees and train staff on the requirement to document cross-gender pat-searches of male detainees.

Recommendation (d): The facility policy does not require cross-gender pat searches of male detainees to be documented. The facility should update the policy to address the language of the standard to include the requirement for cross-gender pat searches of male detainees to be documented.

(g): Policy OCCJA/2.10 directs that "detainees will be allowed to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera) or as otherwise appropriate in connection with a medical examination or monitored bowel movement". Interviews with security staff and with the Director of Nursing (DON) confirmed that male officers are assigned to provide observation of a detainee when on suicide watch or during a monitored bowel movement, and that no such occurrences have been necessary in the past 12 months. The PSA Compliance Manager provided the Auditor with a tour of the camera system to observe camera views, and "shade-outs" in shower and toilet areas.

Policy OCCJA/2.10 does not establish the requirement for opposite gender staff to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothes; however, the Auditor observed staff of the opposite gender making announcements upon entering the housing units, and staff confirmed during interviews that they are required to be made. Of the detainee interviews, 8 of 20 stated that the announcements are made, while the other 12 either stated they were not, or that they were not sure if they were made.

Does Not Meet (g): The facility's policy does not include the requirement for opposite gender staff to announce their presence. The policy and procedure must require staff of the opposite gender to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothes. The facility must update the policy to address the standard language with procedural direction for staff and train staff on the updated policy. The facility must provide the updated policy with documented staff training on the policy for compliance review.

(h): The facility is not a family residential facility; therefore, this provision is not applicable.

(i): Policy OCCJA/2.10 directs that "staff will not search or physically examine a transgender or intersex detainee for the sole purpose of determining the detainee's genital status." "If the detainee's genital status is unknown, it may be determined through conversation with the detainee" and "the detainee will be asked whether they consider themselves male or female." Interviews with staff confirmed their knowledge that this type of search is prohibited and that they were not aware of any transgender or intersex detainee housed at the facility within the audit period. The DON explained that there is a policy in place for medical to be notified if a transgender detainee is identified, at which time more information will be obtained by medical personnel.

(j): Policy OCCJA/2.10 states "the agency shall train security staff in proper procedures for conducting pat-down searches, including cross-gender pat-downs and searches of transgender and intersex detainees. All pat-down searches shall be conducted in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety." The Training Coordinator confirmed during his interview that he trains all staff on how to conduct a proper, respectful, and professional search. The Auditor reviewed the lesson plan for Search Techniques and found it inconsistent with the facility's policy on searches. The lesson plan states, "if there is not an officer of the same gender as the inmate immediately available, the officer may go ahead with the search." The lesson plan does not explain exigent circumstances, nor does it explain that opposite-gender searches must be documented. In addition, the training presentation does not include any instruction on searches of transgender and intersex detainees. Records were provided for 18 officers who attended training on 03/09/2021.

Does Not Meet (j): The facility's training curriculum does not include instructions for transgender/intersex searches, nor does it explain exigent circumstances for opposite gender searches and the requirement to document these searches. The facility must train security staff in proper procedures for conducting searches of transgender and intersex detainees in a professional and respectful manner and in the least intrusive manner possible consistent with security needs and agency policy, including consideration of officer safety. The facility must provide the training curriculum for transgender and intersex pat-down searches and documentation of staff training for compliance review.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy OCCJA/2.10 establishes that "procedures have been established to provide disabled detainees equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment." These procedures include detainee educational materials being in "formats accessible to all detainees in accordance with Title II of the Americans with Disabilities Act, 42 U.S.C.". The policy specifies that "interpreter services will be provided for deaf or hard of hearing detainees; interpreter services will be provided for non-English-speaking detainees; staff will read the material to detainees." "The agency shall provide in person or telephonic interpretation services that enable effective, accurate, and impartial interpretation" per policy. The Auditor reviewed the facility's detainee handbook and found that detainees with a disability are advised they have a right to reasonable access to all programs, activities, and services available to other detainees; and the right to be provided aids or services to communicate, see, or hear. The facility's detainee handbook also includes the "I Speak… Language Identification Guide" and these guides are also posted in the housing units. Detainees may request interpretive services for essential communications by filling out a request form, from any facility or ICE officer. The facility provided a copy of the DHS Zero-Tolerance PREA poster in English and Spanish with the name of the PSA Compliance Manager. However, the posters displayed at the facility during the on-site visit did not have the name of the PSA Compliance Manager identified. The Auditor also made a recommendation to add these posters to the visitation area. While the facility's detainee handbook is published in English and Spanish, the facility did not have available any ICE National Detainee Handbooks in languages other than English and Spanish. Based on interviews with the PSA Compliance Manager and the Director of Operations, the facility's detainee handbook and the ICE National Detainee Handbook is made available to detainees through the kiosk in both English and Spanish. The Auditor attempted to access the ICE National Detainee Handbook through the kiosk with the assistance of a detainee unsuccessfully. The PSA Compliance Manager was made aware and said she would look into the problem which was not resolved by the conclusion of the on-site visit. The facility stated they would obtain the electronic versions of the ICE National Detainee Handbook in the other languages and upload them to the kiosk. The ICE National Detainee Handbook is available in English, Spanish, Punjabi, Russian, Arabic, Chinese, French, Haitian Creole, Portuguese, Hindi, Romanian, Turkish, Bengali, and Vietnamese. Based on detainee interviews, it does not appear that the DHS-prescribed Sexual Abuse and Awareness Information pamphlet is provided to each detainee. The pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi.The pamphlet is incorporated into the facility's detainee handbook in English and Spanish; however, the detainee interviews indicated that none had received the facility's detainee handbook. As indicated above, Interviews with the PSA Compliance Manager and the Director of Operations indicated detainees are not provided a hard copy of the handbook; rather, they can be accessed through the kiosk. There is a copy of the pamphlet for general access in each housing unit in English and Spanish only. Additionally, each housing unit had a poster of local organizations that assist detainee sexual abuse victims available in English, Spanish, and Punjabi.

There were no detainees at the facility during the on-site visit, who were identified as having a hearing, visual, or cognitive disability, to interview. The Auditor used Creative Correction's Language Line Services to interview 13 of the 20 detainees interviewed. Of the 13 interviewed, 10 detainees stated that they were provided an interpreter, either by phone or in person, during the intake process. Of the remaining three detainees, one detainee stated that staff attempted to provide an interpreter by phone, but the service could not connect them with anyone who spoke his language (Wolof) at that time. Interview with intake staff confirmed that several attempts had been made through their interpreter service but the service was not able to find anyone who spoke that language. This detainee also told the Auditor that he could not read or write, so any written material would not be helpful. At the time of the audit, this detainee had not been provided the SAAPI information in a manner or format that he could understand. The Auditor referred

this detainee to the PSA Compliance Manager for SAAPI education with the use of an interpreter. The files for the other two detainees did not indicate that an interpreter was used during intake. During interviews with the LEP detainees, the Auditor was told by 2 of the 13 detainees that they had received a copy of the ICE National Detainee Handbook and the others said they had not. Each detainee's file reviewed contained signed documentation that they received a handbook; however as noted above, the detainees are not actually given hard copies of the handbooks, rather they have to use the kiosk to access them, which are only available in English and Spanish. When asked if they received information on SAAPI, three detainees stated "yes," and that they saw the DHS PREA posters and watched the Detainee Orientation video. During the interview with the Director of Operations, he explained that each housing unit is equipped with a kiosk that is used for multiple purposes for detainees to access commissary items, communicate with the facility staff, and to access important facility communications such as the orientation materials and video. The remaining 10 detainees stated either they had not seen the video, or if they did, stated it was in English. Everyone, except the detainee who indicated that they could not read or write, was aware of the DHS PREA posters in the housing units.

The Director of Operations explained during his interview that Language Line Services is used by staff when there is a language barrier, but they do not keep a log of calls made. He stated that the facility has a nurse on staff that is bi-lingual (Spanish), and that staff frequently use mobile phone applications such as Google/Apple Translate to communicate with LEP detainees. Several staff members interviewed by the Auditor also mentioned that they utilize these applications.

Does Not Meet (b): The facility has not demonstrated compliance with provision (b) which requires the facility to ensure meaningful access to all aspects of the agency and facility's efforts to prevent, detect, and respond to sexual abuse with detainees who are LEP. While it appears that the facility is using interpreter services during the intake processing, it does not appear that SAAPI information is presented in a language of the detainee's understanding for those who speak/understand a language other than English and Spanish. The facility does not appear to be handing out the ICE National Detainee Handbook, which is available in 14 languages. Each detainee's file reviewed contained signed documentation that they received a handbook; however, the detainees are not actually given hard copies of the handbooks, rather they have to use the kiosk to access them, which are only available in English and Spanish. The facility does not appear to be making available the Sexual Abuse and Awareness Information pamphlet to each detainee, which is available in 9 languages. The facility must provide meaningful access to all aspects of the agency and facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are LEP. The facility must develop a process to ensure that all LEP detainees receive SAAPI information in a language and manner they understand and receive the ICE National Detainee Handbook in a language they understand. The facility must ensure all LEP detainees receive meaningful access to SAPPI information including the issue of the ICE National Detainee Handbook in a language of their understanding.

(c): Policy OCCJA/2.10 states the facility does not "rely on detainee interpreters, readers, or other types of detainee assistants except in limited circumstances, and must be fully documented, where an extended delay in obtaining an effective interpreter could compromise the detainee's safety, the performance of first-response duties, or the investigation of the detainee's allegations." Interviews with the PSA Compliance Manager and the Director of Law Enforcement confirmed that there have been no requests for the use of detainees as interpreters for a related PREA allegation during the audit period, but if there is a request, it will be handled on a case-by-case basis. The Auditor's review of the two investigative files for allegations reported during the audit period and found no documentation to indicate that an interpreter was needed, requested, or utilized during the investigation for the alleged victim or alleged perpetrator.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy OCCJA/2.10 "prohibits hiring or promoting anyone who may have direct contact with detainees and prohibits enlisting the services of any contractor who may have contact with detainees who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; or who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercions, 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 the activity described in this section." Per this policy, "incidents of sexual harassment will be considered in determining whether to hire or promote anyone or to enlist the services of any contractor who may have contact with detainees; and consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse."

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 Contractor Personnel Directive 6-8.0, requires anyone entering or remaining in government service, employee or contractor undergo a thorough background examination for suitability and retention. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in October 2020 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.

The Auditor requested through the OPR PSO Unit confirmation of background checks for three ICE employees who work at the facility. All three have a current background investigation completed based on the information provided by the PSO Unit. The Auditor reviewed nine employee personnel files and found evidence of background record checks for newly hired employees, but not for longer standing employees. The PSA Compliance Manager stated that previously the background checks were not being retained so there was no evidence that these had been conducted. Based on the Auditor's review of the OCCJA Applicant Questionnaire & Background Investigation Form, review of personnel records, and interview with the Director of Operations, the facility does not ask all applicants who may have contact with detainees directly about previous misconduct described in this standard, either in written applications or interviews for hiring or promotions and in interviews or written self-evaluations conducted as part of reviews of current employees. In addition, per the policy and interview with the Director of Operations, a criminal background check is completed before hiring any new employee who may have contact with detainees, which was confirmed through interview with the Director of Operations, although review of personnel files did not support compliance. Policy OCCJA/2.10 states "criminal background records checks will be conducted by the Director of Operations or his/her designee on all current employees, volunteers, and contractors, who may have contact with detainees at least every five years." Although, the Director of Operations disclosed during his interview that the five-year background checks are not conducted, nor required to be conducted, because their facility is not an immigration-only detention facility. There was no documented evidence that prior institutional employers were contacted for

information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse, although during interviews the Auditor was told that it is done.

Does Not Meet (b): The facility does not ask staff, who may have contact with detainees directly, about previous misconduct described in this standard, neither in written applications or interviews for hiring or promotions, nor in interviews or written self-evaluations conducted as part of reviews of current employees. The facility must develop a process to ensure all staff who may have direct contact with detainees are questioned about previous misconduct described in this standard, either in written applications or interviews for hiring or promotions and in interviews or written self-evaluations conducted as part of reviews of current employees. The facility must provide documentation the process is in practice for compliance review. In addition, the facility must document that prior institutional employers were contacted for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of an allegation of sexual abuse.

Does Not Meet (c): Personnel files were missing documentation that background checks were conducted on all employees who may have contact with detainees; therefore, the Auditor was unable to confirm facility employees received a background check prior to having contact with detainees. The facility must conduct background checks on all employees who may have conduct with detainees before hiring. The facility must develop a process to ensure backgrounds checks are conducted on all staff who may have contact with detainees prior to hiring. The facility must provide examples of background checks conducted prior to hiring for compliance review.

(d): Policy OCCJA/2.10 further asserts that a criminal background check be completed before enlisting the services of any contractor who may have contact with detainees. Review of one contractor file found that background checks have not been completed on the contractor. Interviews with the Director of Operations and the PSA Compliance Manager further confirmed that although their policy indicated background checks would be performed on contractors before enlisting their services, they are not completed. Further outlined in the policy, "upon by request by the agency, the facility shall submit for the agency's approval written documentation showing the detailed elements of the facilities background check for each contractor and the facility's conclusions."

Does Not Meet (d): Background checks have not been completed on the mental health contractors who provide services for the facility. The facility must conduct background checks on all contractors who may have conduct with detainees before hiring. The facility must develop a process to ensure backgrounds checks are conducted on all contractors who may have conduct with detainees prior to hiring. The facility must provide five examples of background checks conducted prior to hiring of services for compliance review.

(e): Policy OCCJA/2.10 establishes that "employees must disclose any misconduct," included within this standard, and that "any material omission(s) regarding such misconduct, or the provision of materially false information shall be grounds for termination or withdrawal of an offer of employment." The interview with the Director of Operations confirmed that he reviews the hiring packet for all applicants and that that no applicant will be offered employment if any misconduct has been discovered, or for providing false information. He further confirmed that no employee has been terminated or that there has been no withdrawal of an offer of employment for this cause.

(f): Policy OCCJA/2.10 establishes that "unless prohibited by law, the OCCJA shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." Based on interview with the Director of Operations, there have been no requests from an institutional employer within the audit period; however, if they receive one, the request will be answered in collaboration with the Law Enforcement Division.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): Based on interview with the Director of Operations, the facility has had no facility upgrades or expansions/upgrades to the video monitoring system within the audit period.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Based on Policy OCCJA/2.10, the facility will "follow a uniform evidence protocol that minimizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions and shall be developed in coordination with DHS." While it has been established that an outside entity is responsible for conducting both administrative and criminal investigations, the PSA Compliance Manager and her back-up are both specially trained sexual abuse investigators and may potentionally be actively involved in an administrative investigation in conjuction with the Law Enforcement Division. Therefore, the facility is required to develop evidence protocols as outlined in this standard. The Auditor reviewed the facility's evidence protocols and found protocols to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. However, the facility did not provide documentation the evidence protocols were developed in coordination with DHS.

The agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform 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 Enforcement and Removal Operations 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 the Inspector General (OIG), OPR, or the local law enforcement agency, the ICE AFOD would assign an administrative investigation to be conducted.

Does Not Meet (a): The facility did not provide documentation the evidence protocols were developed in coordination with DHS. The facility needs to document the coordination with DHS.

(b)(c)(d): Policy OCCJA/2.10 establishes that "the facility attempts to make available to the victim a victim advocate from a rape crisis center, in person or by other means" and "a qualified staff member from a community-based organization or a qualified agency staff member will be provided if rape crisis center service is not available." The policy further provides that "all victims of sexual abuse will be offered access to forensic medical examinations (FME) at no cost to the victim." These FMEs will be conducted at a local hospital and will be conducted by Sexual Assault Examiners (SAFEs) or Sexual

Assault Nurse Examiners (SANEs) according to interviews with the DON and Director of Law Enforcement. "As requested by the victim, available advocacy services will be allowed during a forensic exam and investigatory interviews" as per policy. The facility has a Memorandum of Understanding (MOU) with the Okmulgee County Family Resource Center to provide SANE examinations, victim advocates during the SANE exam, and counseling. After a report of a sexual assault has been received, an investigator will contact the Muscogee Nation Family Violence Prevention Program (FVPP) to dispatch the SANE, provided the detainee consents to the examination. The Muscogee Nation FVPP will provide an advocate during the SANE exam for emotional support and explanation of processes and available services during and after incarceration with the OCCJA. Based on the Auditor's review of the two investigation files and interviews with the PSA Compliance Manager and Director of Operations, there were no forensic exams conducted during the audit period. One of the two investigative files indicated that the victim advocate handout was provided, and neither file indicated that a victim advocate was requested.

(e): Based on review of the OCCJA Organizational Chart and interviews with the Director of Operations and the Director of Law Enforcement, the OCCJA has its own law enforcement division and conducts its own criminal and administrative investigations, which was further confirmed through documentation in the two investigative files. The Director of Operations confirmed both in writing, and during his interview, that the OCCJA-MDF own law enforcement division conducts investigations in accordance with provisions (a) through (d) of this standard.

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

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

Notes:

(a)(b)(d): Policy OCCJA/2.10 establishes that the "OCCJA ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment and requires that all referrals for criminal investigations of sexual abuse be documented and maintained for a minimum of five years." Based on the review of the OCCJA Organizational Chart and interviews with the Director of Operations and the Director of Law Enforcement, the OCCJA has its own law enforcement division, which is the responsible entity with legal authority to conduct its own criminal and administrative investigations. Interviews with the PSA Compliance Manager, the Director of Operations, and the Director of Law Enforcement confirmed that all allegations are presented to the Director of Law Enforcement for review and assigned to an investigator. There were two allegations received during the audit period and both were investigated by the OCCJA Law Enforcement Division. The PSA Compliance Manager confirmed that the investigation files will be maintained for at least five years. The facility's policy was reviewed and approved by the ICE AFOD on 11/13/20.

The agency's policy 11062.2 outlines the evidence and investigation protocols. All investigations are to be reported to the Joint Intake Center (JIC) who assesses allegations to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation, and the ICE AFOD assigns an administrative investigation to be completed.

(c): A review of the ICE website (https://www.ice.gov/prea) confirms the sexual abuse investigation protocols are available to the public. The OCCJA website is currently in the final stages of development according to interview with the Director of Operations. Once completed, the protocols will be posted. Currently, the protocols will be made available to the public upon request.

(d)(e)(f): Policy OCCJA/2.10 establishes that "when a detainee is alleged to be the perpetrator of sexual abuse, the facility shall ensure that the incident is properly reported to the Joint Intake Center (JIC), the ICE Office of Professional Responsibility (OPR), or the DHS Office of Inspector General (OIG), as well as the appropriate [F]ield Office Director, and if it is potentially criminal, referred to the appropriate Law Enforcement agency that has jurisdiction for investigation. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is immediately reported to the JIC, the ICE/OPR, the DHS/OIG, as well as the appropriate field office director, and to the local government entity or contractor that owns or operates the facility." According to interviews with the Director of Operations and the Director of Law Enforcement, the ICE/SDDO is notified upon receipt of an allegation of sexual abuse and an investigation is started immediately. During the Auditor's interview with the SDDO, he explained that the facility makes immediate notification to his office then he makes notification the ICE AFOD/FOD within two hours. A local investigation will begin, and notifications will be made to the JIC, ICE OPR, and the DHS OIG. The Auditor's review of the two investigations found documentation that ICE ERO, JIC, and ICE OPR were notified, as required.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b): Policy OCCJA/2.10 requires employee training "on the facility's Sexually Abuse and Assault Prevention and Intervention Program (SAAPI) program during initial and annual refresher training." This initial and annual refresher training includes "the facility's zero-tolerance policy for sexual abuse and sexual harassment; the right of detainees and staff to be free from sexual abuse and from retaliation for reporting sexual abuse; definitions and examples of prohibited and illegal sexual behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional signs of sexual abuse and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees, including LGBTI or gender non-conforming detainees; procedures for reporting knowledge or suspicion of sexual abuse; and the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes." The facility utilizes the "ICE PREA Training for Contractors and Volunteers" presentation, which covers all the elements (1-9) required in provision (a). The Training Coordinator explained that he is in the process of developing a new curriculum inclusive of search procedures, and specific to the facility, which he hopes to roll-out later this year. Staff interviews conveyed to the Auditor that they understood the information provided during the PREA training. The Training Coordinator stated that PREA training occurs annually, which exceeds the standard requirement.

(c): Training records reviewed by the Auditor found that employees are trained upon hire and then again annually. Training is documented through employee signature on the training sign-in sheet and by signature on the acknowledgement statement that they understand the training. The Training Coordinator explained, during his interview, that he is new to his position and is auditing all the employee files currently, to ensure that all employees are current on their training requirements. He said that the PREA training is delivered annually and that employees sign both the sign-in sheet, and the

acknowledgement statement that they understand the training. Training records are retained by the Training Coordinator with a copy in the employee's personnel file. The Auditor reviewed training files for nine employees and found documented training, and the signed acknowledgement forms were present in the employee's personnel file. The Auditor interviewed one ICE employee while on-site who was unable to confirm that he was current with his SAAPI training; upon requesting verification of training records, a certification of completion for 08/12/2021 was provided.

Recommendation: Policy OCCJA/2.10 under section 115.31 states in the introduction that the employee training will occur annually, which conflicts with section A.4, where it states refresher course will be provided every two years. The Training Coordinator confirmed that training occurs annually. The Auditor recommends updating the policy to be consistent with the annual training requirement and the facility's practice.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c): Policy OCCJA/2.10 requires "all volunteers and contractors, who have contact with detainees, will be trained on their responsibilities under the PREA." At a minimum, "volunteers and contractors have been notified of the zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents; the type and level of training is based on the services they provide and level of contact they have with detainees." The chaplain confirmed, during his interview, that he supervises the volunteers and that they are required to take the ICE Contractor/Volunteer training annually in January. The Training Coordinator delivers the training for contractors and volunteers during the annual training and also individually, as needed, as they are brought on board through the year. The Auditor reviewed records for two volunteers and one contractor and found signed acknowledgement forms where they have received the training annually, which is found to exceed requirement of this standard.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy OCCJA/2.10 establishes that "all detainees, during intake, will receive orientation explaining the facility zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment." The policy further establishes that this orientation will include "prevention and intervention strategies; definitions of sexual abuse, and coercive sexual activities; explanations of methods for reporting sexual abuse; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including and explanation that reporting sexual abuse shall not negatively impact the immigration proceedings; and the right of a detainee who has be subjected to sexual abuse to receive treatment and counseling." Per policy, the "PREA education is available in accessible formats for all detainees including those who are LEP, deaf, visually impaired, otherwise disabled, or limited in their reading skills." There were no new intakes during the on-site visit for the Auditor to observe, but a simulation was provided. The Auditor reviewed the facility's orientation presentation "Moore Detention Facility Handbook Orientation" which is available in both English and Spanish and the only SAAPI reference in the orientation material is the statement "the facility has a zero tolerance for all forms of sexual abuse". Additionally, the Booking Officer required is to show the Detainee Orientation video as part of orientation. The Detainee Orientation video is a PowerPoint presentation that plays on the tv screen while detainees are being processed. There is one slide that presents the Sexual Abuse and Prevention/PREA zero-tolerance information; however, the orientation does not include prevention and intervention strategies; definitions of sexual abuse, and coercive sexual activities; explanations of methods for reporting sexual abuse; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including and explanation that reporting sexual abuse shall not negatively impact the immigration proceedings; and the right of a detainee who has be subjected to sexual abuse to receive treatment and counseling. Based on interviews with the PSA Compliance Manager and intake officers, this presentation plays on a loop and is presented in both English and Spanish. There is no formal orientation process where detainees are provided instruction. The Director of Operations explained that the video is installed on the kiosk and that each detainee must view the video, which documents through electronic signature their understanding before any other services is accessible to them through the kiosk. However, the video is only presented in English and Spanish, and not every detainee will have need to access the kiosk; therefore, some detainees may never see the video if they do not view it during processing or have a need to access the kiosk otherwise. The simulation and historical video of the intake procedures observed by the Auditor further confirmed that the facility is not providing all of the required information to detainees at intake. Based on the simulation, observation of historical video footage of a recent intake, and interviews with detainees, the facility has not demonstrated compliance with subparts (a) and (b) which requires the facility to provide instruction on the SAAPI program.

Based on interviews with the detainees and the information provided by the PSA Compliance Manager and Director of Operations, it appears that the facility is relying solely on the electronic information available on the kiosk and the tv in the processing area to convey the SAAPI information to the detainee population. The facility did not have available any ICE National Detainee Handbooks in languages other than English and Spanish. Based on interviews with the PSA Compliance Manager and the Director of Operations, the facility handbook and the ICE National Detainee Handbook is made available to detainees through the kiosk in both English and Spanish. The Auditor attempted to access the ICE National Detainee Handbook through the kiosk with the assistance of a detainee unsuccessfully. Of the 20 detainees interviewed, only two stated they received an ICE National Detainee Handbook.

The ICE National Detainee Handbook is available in English, Spanish, Punjabi, Russian, Arabic, Chinese, French, Haitian Creole, Portuguese, Hindi, Romanian, Turkish, Bengali, and Vietnamese. The DHS-prescribed Sexual Abuse and Assault Awareness pamphlet is incorporated into the facility's detainee handbook in English and Spanish; however the detainee interviews indicated that none had received the facility's detainee handbook. The pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi.

(c): Policy OCCJA/2.10 requires the detainee "to sign documentation of participation in the PREA education sessions." The Auditor reviewed the detention files of the 20 detainees interviewed and observed a signed copy of the Moore Detention Center PREA/Video Detainee Checklist which indicates receipt of the facility's detainee handbook and ICE National Detainee Handbook, and Detainee Orientation video. Based on interviews with the PSA Compliance Manager and intake staff, detainee signatures are obtained on this checklist during the intake process, and not necessarily after all the information on the list is provided. The Auditor discussed the orientation procedures with the Director of Operations who further confirmed that the facility relies on the kiosk for delivery of the PREA education.

Does Not Meet (a)(b)(c): Based on the observed intake simulation, Detainee Orientation video, observation of historical video footage of a recent intake, and interviews with detainees, the facility has not demonstrated compliance with (a)(1-6) which requires the facility provide instruction on the SAAPI program. The orientation does not include prevention and intervention strategies; definitions of sexual abuse, and coercive sexual activities; explanations of methods for reporting sexual abuse; information about self-protection and indicators of sexual abuse; prohibition against retaliation,

including and explanation that reporting sexual abuse shall not negatively impact the immigration proceedings; and the right of a detainee who has be subjected to sexual abuse to receive treatment and counseling. The facility provides SAAPI training only in English and Spanish through the Detainee Orientation Video and the facility's Detainee Handbook. Further, SAAPI education is not provided to LEP detainees in a language and manner they can understand and the ICE National Detainee Handbook is not provided to detainees. The facility must develop a detainee orientation program that covers all elements of this subpart, staff must be trained on the new orientation process, and the detainees must be provided SAAPI training to include prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse andcoercive secual activity; explanation of methods for reporting sexual abuse; informationation about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. In addition, the SAAPI orientation program must be provided to all detainees in a manner of their understanding, so they have access to the full SAAPI program including the issuance of the ICE National Detainee Handbook in a language they understand. The facility must provide documentation demonstrating ten new intakes received the updated orientation program which must include all elements of subpart (a) for compliance review. The facility must also provide documentation demonstrating five new detainees who are LEP, in languages other than Spanish, were provided the updated orientation in a language of their understanding. The LEP detainee files should document the language the orientation was provided in and should include the language of the ICE National Detainee Handbook issued.

(d)(f): Policy OCCJA/2.10 states that "posters containing sexual assault awareness and reporting information are posted in the pre-booking and booking areas for detainees who make bond prior to being moved to population." The policy further establishes "that key information about the agency's PREA policies is continuously and readily available or visible through posters, 30-day comprehensive education, detainee handbooks, or other written formats. Policies material will be available in a language that detainees can comprehend." There is no documentation to support that a 30-day comprehensive education occurs. The Auditor observed the DHS-prescribed Sexual Assault Awareness notice posted in all housing units, but the name of the PSA Compliance Manager needed to be added. The detainee interviews further supported that these posters are readily available throughout the facility and the Auditors observed this information posted as described in all housing units and in common areas throughout the facility. The Auditor recommended a poster be added to the Visitation/Multi-Purpose Area. Of the 20 detainees interviewed, only 2 stated they received an ICE National Detainee Handbook (1-English/1-Spanish). The facility did not have the ICE National Detainee Handbook available in languages other than English and Spanish but requested the additional handbooks in PDF from ICE. The PSA Compliance Manager and the Director of Operations advised the Auditor that they would have the ICE National Detainee Handbook uploaded to the kiosk; however, this was not completed prior to the end of the on-site visit.

Does Not Meet (d)(f): Based on the Auditor's observations of the simulated intake, reviewed video intake, and interviews with staff and detainees, the facility is not providing the ICE National Detainee Handbook to detainees. The facility must develop a process to ensure all detainees receive the ICE National Detainee Handbook and ensure the handbook is provided in a language the detainee understands. The facility must provide the process, documented staff training on the requirement to issue the ICE National Detainee Handbook, and documentation of ten new LEP detainee intakes (at least five LEP detainees) receiving the ICE National Detainee Handbook for compliance review. The name of the PSA Compliance Manager must be listed on the DHS-prescribed sexual assault awareness notices posted at the facility.

(e): Policy OCCJA/2.10 states that "a sexual assault awareness pamphlet is provided to each detainee during admission with information on self-protection and prevention techniques, treatment and counseling, and reporting methods." The facility had only pamphlets available in English and Spanish, yet the DHS-prescribed Sexual Abuse and Assault Awareness Information pamphlet is available in nine languages: English, Spanish, Arabic, Haitian Creole, French, Hindi, Portuguese, Punjabi, and Chinese. None of the detainees reported receiving the DHS-prescribed sexual assault awareness pamphlet. The facility's detainee handbook contains the DHS-prescribed Sexual Abuse and Assault Awareness Information pamphlet, but detainee interviews indicated that they did not receive a copy of the facility's detainee handbook at intake. The PSA Compliance Manager explained that these pamphlets, if available in PDF, can be added to the kiosk so the detainees can access them electronically. The Auditor checked with the PSA Compliance Manager on the last day of the audit to inquire if the pamphlets had been uploaded to the kiosk in order to verify before the outbriefing but was told that they had not been uploaded. The Auditor observed that a laminated copy of the pamphlet was available on each housing unit available in English and Spanish.

§115.34 - Specialized training: Investigations.

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

Notes:

(a)(b): Policy OCCJA/2.10 establishes that "in addition to the general training provided to all facility staff and employees pursuant to 115.31, the facility shall provide specialized training on sexual abuse and effective cross-agency coordination to agency or facility investigators, respectively, who conduct investigations into allegations of sexual abuse." There were two allegations reported within the audit period and both were investigated by a detective from the OCCJA Law Enforcement Division. Based on interviews with the PSA Compliance Manager and the Director of Law Enforcement, both criminal and administrative investigations will be referred to the Law Enforcement Division and he is requiring the investigators who will be assigned to investigate sexual abuse allegations to complete the specialized training, although this is not a requirement since they are a separate law enforcement entity. While it has been established that an outside entity is responsible for conducting both administrative and criminal investigations, the PSA Compliance Manager and her back-up are both specially trained sexual abuse investigators and may potentionally be actively involved in an administrative investigation in conjuction with the Law Enforcement Division. Based on the Auditor's interviews and review of the training certificates, the PSA Compliance Manager, and her back-up coordinator has completed the "PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations" by the National Institute of Corrections (NIC).

Agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The Auditor reviewed the ICE OPR Investigations Incidents of Sexual Abuse and Assault training curriculum and found the curriculum covers in-depth investigative techniques, evidence collection, and all aspects to investigating of sexual abuse in a confinement setting. The agency also offers a Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP, LGBTI, and disabled detainees and an overall view of the investigative process. The agency provided rosters of trained investigators for the Auditor's review. One of the investigations was referred to OPR and the assigned investigator had received specialized investigation training.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The Director of Operations provided a written statement and confirmed during his interview that the facility has no Immigration Health Services Corps/U.S. Public Health Service (IHSC/USPHS) staff at the facility. These sections are non-applicable.

(c): Based on interviews with the Director of Operations, Director of Law Enforcement, and the DON, it was determined that the facility's medical staff does not conduct forensic examinations of sexual abuse victims; however, they may examine and provide treatment for any urgent medical issue to stabilize the detainee prior to being transported to the hospital for further treatment and examination. Mental health services are contracted out to a local community provider. The facility's medical staff and the mental health contractors have all received the basic training required in accordance with 115.31 and 115.32. The facility's policy and procedures were reviewed and approved by the ICE AFOD on 11/13/20. Policy OCCJA/2.10 requires specialized training for medical and mental health care, but the facility's medical staff have not received specialized training.

Does Not Meet (c): The facility medical staff is required to have specialized training to include the following topics at a minimum: how to detect and assess signs of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; How and to whom to report allegations or suspicions of sexual abuse; and how to preserve physical evidence of sexual abuse. All facility medical staff and mental health care providers are required to complete this training and present training documentation/certificates for compliance review. The facility must provide specialized training with facility medical staff. The facility must provide documentation of specialized training with facility medical staff for compliance review.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy OCCJA/2.10 directs "all detainees will be screened during intake and upon transfer to another facility using an objective instrument for their risk of being sexually abused by other detainees or sexually abusive toward other detainees in attempt to prevent such behavior. Each new arrival shall be kept separate from the general population until he is classified and may be housed accordingly." According to interviews with the intake staff, the PSA Compliance Manager, and the Director of Operations, detainees are held in the intake area until they are processed, classified, and screened, unless there is a large intake. In those cases, housing unit Z is used as a staging area where detainees are placed in two-person cells randomly and staff conduct the intake process in the common area of the housing unit. According to the interviews, these detainees are moved to appropriate room assignments once the risk screening is completed, and that no one is left assigned to that initial location beyond the booking period without a risk screening being completed. Also, per policy, "the intake screening and housing assignment will take place within 12 hours of arrival at the facility and with a reassessment of the detainee, by classification no later than 30 days from the detainee's arrival based upon any additional, relevant information received by the facility since the intake screening." All 20 detainee files reviewed indicated that the intake screening was conducted on the same date as their arrival. While there was no time stamps, staff and detainee interviews indicated the intake screenings were conducted within 12 hours. Additionally, there were no documented files indicating that a 30-day classification review was conducted. Based on interviews with the Director of Operations and the PSA Compliance Manager, there is no system in place for tracking high risk detainees. Without a system in place to track these detainees, the facility has not demonstrated their ability to keep separate likely abusers from detainees likely to be victimized.

Did Not Meet (a)(b): The facility has no system in place for tracking high risk detainees and has not demonstrated their ability to keep separate likely abusers from detainees likely to be victimized. The facility must develop a system to track detainees who are high risk for sexual abusiveness, and those who are at high risk for sexual victimization and present to the Auditor for compliance review. The Auditor was unable to confirm initial classification process and initial housing assignment for detainees were completed within twelve hours of their admission. The facility must develop a process to ensure these actions are completed within 12 hours of admission, and provide 10 samples to the Auditor for review and determination of compliance with the 12-hour requirement.

Recommendation: The facility should remove the 30-day review requirement from Policy OCCJA/2.10 for classification to conduct a 30-day sexual victimization or abusiveness risk reassessment if it is no longer the facility's operating procedure. Otherwise, documentation in the detainee's file should indicate the r date and result of the reassessment.

(c)(d): Policy states "the intake screening will consider at the minimum the following: a) whether the detainee has a mental, physical, or developmental disability; b) age of the detainee; c) physical build of the detainee; d) if the detainee has previously been incarcerated; d): if the detainee's criminal history is exclusively nonviolent; f) if the detainee has prior convictions for sex offenses against an adult or child; g) if the detainee is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; h) if the detainee has previously experienced sexual victimization; i) the detainee's own perception of vulnerability." Based on the Auditor's review, the screening instrument includes the criteria outlined in (1)–(9) of provision (c). Per policy, "the initial screening shall also consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive" which are also included as part of the risk assessment based on the Auditor's review of the screening instrument. Based on interviews with the Director of Operations, PSA Compliance Manager, and Classification Manager, the interviewer's assessment of risk for either sexual victimization or sexual abusiveness is to be determined based on the answers provided to the questions, although there is no guidance or instructions on how to make an assessment based on the responses provided. If the interviewer believes that the detainee could be at risk in either category, the information is brought to the attention of the PSA Compliance Manager, who will then review with the Classification Manager, to determine if special housing needs are warranted. The Director of Operations explained that the facility's current offender management system does not allow for tracking high risk detainees, but he is developing a new system, TIGER, that will self-track PREA risk, and force classification based on a scale. This system is close to being completed and servers were scheduled to be installed the week of the on-site visit. This will be an improvement to the current manual system that is in place.

(e): Policy states "a detainee's risk level shall be reassessed between 60 to 90 days and when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the detainee's risk of sexual victimization or abusiveness." Of the 20 detainee files reviewed, 6 detainees had been at the facility for longer than 60 days, and each of these had a 60–90-day reassessment documented. Interviews with the PSA Compliance Manager and the Classification Coordinator confirmed that the detainee is tracked manually for the 60–90-day review, at which time a reassessment is conducted by classification staff and documented on the original screening instrument, on the second column as indicated. This reassessment is conducted in-person with the detainee according to the Classification Coordinator. There was no documentation provided that indicated the detainees involved in the two reported allegations were reassessed after reporting the allegation at any time.

Does Not Meet (e): The facility does not complete reassessments on detainees involved in an incident of sexual abuse. According to the Performance-Based National Detention Standards (PBNDS) 2011, which the facility is contractually obligated to comply with, reassessments on alleged victims and abusers must be completed within 24 hours of an incident. The facility must develop a process to ensure all alleged victims and abusers are reassessed for risk of sexual victimization and abusiveness within 24 hours and staff must be trained on the process. The facility must document staff training of the process for compliance review. The facility must also provide two examples of detainees receiving reassessments based on an incident of sexual abuse or receipt of additional information within the required timeframe for compliance review.

(f): Policy OCCJA/2.10 states "detainees will not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked during the risk screening related to having a mental, physical, or developmental disability; the detainee's sexual orientation; any previously experienced sexual victimization; or the detainee's own perception of vulnerability." Interviews with case managementstaff confirm that detainees are not disciplined for refusing to answer questions during the screening process.

(g) Policy OCCJA/2.10 requires the facility to "implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees." During the on-site visit, the Auditor observed that the screening instruments, once completed, are maintained in the detainee's file, which is kept in a locked filing cabinet in the administrative assistant's office, which has limited accessibility. Staff disclosed during interviews that they understand the importance of protecting sensitive information, obtained during the intake process, from release and that it is shared only on a need-to-know basis.

§115.42 - Use of assessment information.

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

Notes:

(a): Policy OCCJA/2.10 establishes that "information from the risk screening will be used to determine housing, bed, work, education, and program assignments to prevent detainees with high risk of being sexually victimized from those at the risk of being sexually abusive." "Individualized determinations about how to ensure the safety of each detainee is made by facility staff," per policy. During the interview with the Director of Operations, he explained that there are multiple factors that are considered when making housing decisions, such as assigning a detainee at risk for vulnerability in a bed that has a more direct view from the central control room or placing that detainee in a room on Housing Unit Z with a roommate who has been properly screened and identified to not be an aggressor. He explained that there are limitations to the facility's ability to house detainees who are high risk for vulnerability or at high risk for abusive sexual behavior due to the structure of the facility being dormitory style in two of the housing units. As a last resort, a high-risk detainee may be placed in RHU/SMU temporarily to keep him safe until other suitable housing arrangements can be made. The facility offers no programming and work detail assignments are very few and are all under direct supervision of staff.

(b)(c): Policy 2.10 establishes that "when making assessment and housing decisions for a transgender or intersex detainee, the facility shall consider the detainees' gender, self-identification, and assessment of the effects on the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. The facility shall not base placement decisions of transgender or intersex detainees solely on the identify 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. The facility's placement of a transgender or intersex detainee shall be consistent with the safety security considerations, and placement and programming assignments for each detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee." Based on the statement of fact and interview with the Director of Operations, the facility has housed no transgender/intersex detainees in the audit period. The DON stated, during her interview, that there are procedures in place for the event that a transgender or intersex detainee is booked at the facility; medical will be consulted and then housing decisions will be made in collaboration with ICE. The Director of Operations stated that most likely, once a transgender detainee is identified, the detainee will remain separated in the medical unit until he consults with ICE to arrange a facility move, because the housing structure does not allow for the housing of transgender/intersex detainees, nor the ability to facilitate showering separately from the general population.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy OCCJA/2.10 establishes that "the facility will develop and follow written procedures governing the management of its administrative segregation unit and that the procedures will be developed in consultation with the ICE ERO FOD having jurisdiction for the facility. These procedures must document detailed reason for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault." Policy OCCJA/2.11, Special Management Unit, governing the RHU/SMU, was provided for the Auditor's review but it did not contain the language necessary to comply with the requirements of this standard. Policy 2.10 states that "detainees at high risk for sexual victimization will not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers." The policy further states that "involuntary placement in administrative segregation shall not exceed 30 days. Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If the facility restricts access to programs, privileges, education, or work opportunities, the facility shall document the opportunities that have been limited, the duration of the limitation, and the reasons for such limitations." Based on interviews with the PSA Compliance Manager and the Director of Operations, administrative segregation would only be used as a last resort until alternative and appropriate housing could be determined and would never be over 30 days. The interviews further confirmed that a detainee placed in protective custody for this purpose would continue to have access to all services available to the general population. Based on correspondence from the Director of Operations and confirmed during his interview, the facility has not had any detainees placed in protective custody or administrative segregation regarding PREA in the audit period, which was further confirmed during the Auditor's interview with the SDDO. While the language stated within the OCCJA/2.10 is consistent with the requirements of the standard, the facility has not demonstrated compliance with provision (a) which requires development of written procedures governing the management of its administrative segregation unit, in consultation with the ICE ERO FOD.

Does Not Meet (a): The facility has not developed written procedures governing the management of the administrative segregation unit, in consultation with the ICE ERO FOD, that include detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault, and that a supervisory staff member is required to conduct, at a minimum, a placement review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter. The facility must add the provisions of this subpart, developed in consultation with the ICE ERO FOD, to Policy OCCJA/2.11, Special Management Unit, for compliance review.

(d)(e): Policy OCCJA/2.10 states that "detainees in administrative segregation housing for their protection will be reviewed by a supervisory staff member within 72 hours of their placement in administrative segregation, to determine if the placement is still warranted; and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter." "The facility shall notify the appropriate ICE FOD no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in administrative segregation based on a vulnerability to sexual assault or abuse." The Director of Operations confirmed that any placement of this nature would be reported to the ICE FOD within 72 hours after the initial placement. He further explained that no detainee would remain in involuntary protective custody for an extended period, but if for some reason they were, the reviews would be conducted according to the requirements in subpart (d).

§115.51 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Detainees at the facility may privately report "sexual abuse, sexual harassment, or retaliation by other detainees or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents", per Policy OCCJA/2.10. The policy establishes the methods for reporting to include: "verbal reporting; grievance forms; request forms; call Rape Crisis Intervention Hotline at 877-756-2545 (non-recorded); write to Okmulgee County Family Resource Center at PO Box 73, Okmulgee, OK 74447; call National Sexual Abuse Hotline at 1-800-656-4673 (non-recorded line); ICE's Community and Detainee Hotline 1-888-351-4024 or #9116." The policy further explains that "detainees detained solely for civil immigration purposes must be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security." Numbers to the consular officials are provided on the Homeland Security Okmulgee County Jail (74447) publication and provided as free calls to all ICE detainees. This publication was observed in each housing unit and includes instructions on how to access the number pro-bono (without charge). The publication also advises detainees that anonymous calls may be made to the Detainee Reporting and Information Line (DRIL), JIC, or DHS OIG, and provides instructions for placing these calls. The Auditor, while accompanied by the PSA Compliance Manager,attempted to place a call, using the instructions for an anonymous call, from the detainee phones and was not able to complete the call using the instructions published for detainee use.The Auditor requested a test pin from the PSA Compliance Manager to place a test call to the other numbers listed for detainee reporting, but the facility was unable to provide a test pin. The telephone numbers should be tested prior to publishing instructions to ensure that the calls can be completed.

Does Not Meet (a): The telephone reporting methods accessible to the detainees that allow private, confidential, and anonymous reporting were not functionable. The Auditor was unable to place a test call from the facility without a PIN being entered.The facility must provide reporting methods to the detainees that are private, confidential and can be anonymous and instructions should be verified to ensure the calls can be completed. These calls should be accessible by detainees without requiring entering a PIN that would identify the detainee.

(b): Policy OCCJA/2.10 "provides ways for detainees to report abuse or harassment to a public or private entity or office that is not part of the agency by: a) National Sexual Abuse Hotline at 1-800-656-4673 (non-recorded line) and b) MOU with Okmulgee County Family Resource Center. The entity receiving the allegation shall be able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing them to remain anonymous upon request." The DHS OIG poster was also observed in each housing unit, providing the toll-free number, TTY number, fax number, mail correspondence address, and website. Complaints may be made anonymously and confidentially through any of these methods to the DHS OIG.

(c): Policy OCCJA/2.10 requires staff to "accept reports made verbally, in writing, anonymously, and from third parties; and to immediately document any verbal reports. All PREA related incidents are to be reported to ICE within 72 hours." The policy further establishes that staff can privately report sexual abuse and sexual harassment of detainees to their supervisor or any other facility supervisor. The staff interviews confirmed that they were knowledgeable of the multiple methods that detainees may make a report of sexual abuse/harassment and retaliation. Staff understood the importance of immediately documenting any verbal reports and following through to ensure the shift supervisor and the PSA Compliance Manager are notified, and that First Responder Protocols are initiated where warranted. The Auditor's review of the investigation files indicated in the written reports that the PSA Compliance Manager and the shift supervisor were notified of the allegations.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): Policy OCCJA/2.10 establishes that the facility "has an administrative procedure for dealing with detainee grievances regarding sexual abuse and shall allow a detainee to file a grievance regarding an allegation at any time during, after, or in lieu of lodging an informal grievance or complaint. The detainee can submit a grievance at any time regardless of when the incident is alleged to have occurred. Facility staff shall present medical emergencies to the immediate attention of proper medical personnel for further assessment. Decisions on grievances filed regarding sexual abuse will be answered no later than 5 days and within 30 days of an appeal. All grievances relating to sexual abuse including a response, with respect to such grievances, shall be sent to the appropriate ICE FOD at the end of the grievance process." Policy OCCJA/2.10 states that "the facility shall have procedures on identifying and handling time sensitive grievances that involve immediate threat to detainee health, safety, or welfare related to sexual abuse," but does not detail those procedures.

Does Not Meet (c): The facility has not provided documentation to demonstrate full compliance with the standard. The facility reported that no sexual abuse/harassment grievances has been filed in the audit period. However, one of the two investigative files reviewed by the Auditor indicated that the source of the allegation was via grievance. The grievance was not provided to evaluate procedural compliance as requested by the Auditor. The facility must outline emergency grievance/threat response related to provision (c) in OCCJA/2.10, section V.B.3. The facility must provide the grievance and any other grievances related to sexual abuse for compliance review.

(f): Policy OCCJA/2.10 establishes that "third parties, including fellow detainees, staff members, family members, attorneys, and outside advocates are permitted to assist detainees in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of detainees. Staff shall take reasonable steps to expedite requests for assistance from these parties."

The Grievance Coordinator explained during his interview the process for handling grievances regarding sexual abuse and sexual harassment and they were consistent with the procedures outlined in Policy OCCJA/2.10. He further explained that if a grievance indicates an immediate threat to health, safety, or welfare, that protective measures would be immediately implemented. In addition, he explained that if a grievance is received alleging sexual

abuse, it will immediately be forwarded for investigation through initiation of the first responder protocols. He stated that detainees file a lot of grievances in general, but he has not received a grievance related to PREA, since he was assigned as the coordinator, within the past year. The Director of Operations also confirmed that no sexual abuse/harassment grievance was filed during the audit period. However, one of the two investigation files reviewed by the Auditor indicated that the source of the allegation was via grievance. Additional information was requested by the Auditor to clarify the conflicting information and to see how the original grievance was handled. The facility's response to the document request was a memorandum from the PSA Compliance Manager that stated "the detainee did not file any grievances in regards to PREA", which does not explain the conflicting information in the investigative file. The detainee grievance process is covered in the facility's detainee handbook, which is located on the kiosk. Detainee interviews confirmed that they were aware of how to file a grievance.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c): Policy OCCJA/2.10 establishes the requirement for the facility to provide "access to outside victim advocates for emotional support services." This is accomplished by "giving detainees mailing addresses and telephone numbers" and "enabling reasonable communication between detainees and these organization in as confidential a manner as possible." OCCJA has entered into a MOU with the Okmulgee County Family Resource Center, PO Box 73, Okmulgee, OK 74447, for services through written correspondence with detainees. In addition, the detainee may request counseling services through the Okmulgee County Family Resource Center through the PSA Compliance Manager who will coordinate with the center to schedule appointments. The OCCJA also has an agreement with the Muscogee Nation FVPP to offer victims information and access to advocacy services for the duration of the victim's incarceration with OCCJA and follow-up services upon release. The FVPP services are voluntary and are only provided at the request of the victim. The FVPP Victim Advocate will provide the victims assistance throughout the criminal justice process and other supportive services. Detainees also have access to the National Sexual Abuse Line at 1-800-656-4673 (non-recorded line) or 391#; which was posted in each housing unit in English, Spanish, and Punjabi. Detainees may also access support services by calling the Rape Crisis Intervention Hotline at 877-756-2545 (non-recorded) or 541#. The PSA Compliance Manager confirmed during her interview that there are multiple resources available to detainees for accessing advocacy and support services. She also explained that detainees may request mental health services that are provided by a private contractor.

(d): The PSA Compliance Manager explained that the speed dial numbers, and toll-free numbers are not recorded and that outgoing or incoming mail from any of the Victim Services providers will not be inspected. There is no evidence that the facility has notified detainees that these calls are unmonitored. Detainee interviews revealed that detainees believe all calls placed from the housing unit phones will be monitored and recorded. Each housing unit is posted with a notice that all calls may be monitored and recorded, and the facility's detainee handbook states "all telephones are recorded and may be monitored by law enforcement except for legal phone calls."

Recommendation: The facility should consider updating the facility's detainee handbook and including on the posters to notify detainees that the speed dial numbers and toll-free numbers to the outside advocacy services are not recorded.

§115.54 - Third-party reporting.

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

Notes:

Policy OCCJA/2.10 requires the facility to "provide a method to receive third-party reports of detainee sexual abuse or sexual harassment." The DHS/ICE website provides public information for methods of receiving third-party reports. Reports may be made to 1-866-DHS-2-ICE; through the ICE ERO DRIL number at 1-888-351-4024. Third-party reports may also be received by the DHS OIG through their website at www.oig.dhs.gov or toll-free at 1-800-323-8603, or by mailing a complaint to 245 Murray Lane SW, Washington, DC 20528-0305. Based on interview with the Director of Operations, this information will be published to the OCCJA's public website when development is completed. The facility relies on the these methods as third-party reporting options for staff, detainees, and the public.

§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): Policy OCCJA/2.10 requires staff "to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, even if that facility is not OCCJA. All staff are required to immediately report any retaliation against detainees or staff who report such incidents and any neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff members who become aware of alleged sexual abuse shall immediately follow the reporting requirements set forth in the written policies and procedures. Apart from reporting to the designated supervisors or officials and designated state or local services agencies, staff is prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions." Based on interviews and documentation in the two investigation files, the written reports confirmed that staff immediately reported the allegations to the shift supervisor, when they were made aware of the allegations. Staff also conveyed to the Auditor the importance of keeping information pertaining to an incident confidential. The policy was reviewed and approved by the ICE AFOD on 11/13/2020.

(d): Policy OCCJA/2.10 states "if the alleged victim is under the age of 18 or considered a vulnerable adult under state or local vulnerable persons statue, the agency shall report the allegation to the designated state or local services agency under applicable mandatory reporting laws." The facility does not house juvenile detainees. Based on interviews with the DON and the Director of Law Enforcement, a vulnerable adult in Oklahoma is anyone over age 55 or over age 16 with a mental impairment, and requires contacting Adult Protective Services, in addition to conducting a criminal investigation. There have been no sexual abuse incidents involving a vulnerable adult within the reporting period according to interview with the PSA Compliance Manager.

Recommendation: The facility should identify the designated person who is responsible for notifying Adult Protective Services of a sexual abuse incident involving a vulnerable adult. This information should be included in the Coordinated Response Plan.

§115.62 - Protection duties.

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

Notes:

Policy OCCJA/2.10 states "when the facility learns that a detainee is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the detainee." Based on interviews with the Director of Operations, the PSA Compliance Manager, medical staff, security staff, and case managers, the facility will take appropriate protective measures without unreasonable delay to protect the detainee from harm if they become aware that he is subject to substantial risk of imminent sexual abuse. Supervisor staff explained that they detainee would most likely be placed in the medical observation cell temporarily until suitable housing could be arranged, or until the imminent danger no longer existed.

§115.63 - Report to other confinement facilities.

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

Notes:

(a)(b)(c): Policy OCCJA/2.10 states, "upon receiving an allegation that a detainee was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency/facility where sexual abuse is alleged to have occurred, as soon as possible, but no later than 72 hours after receiving the allegation. This notification will be fully documented." The facility provided an example of an allegation that was reported during an OPR Office of Detention Oversight inspection and occurred outside the audit period but demonstrated compliance. The report was documented thoroughly by email, PREA response protocols were initiated, notification was made to OPR JIC, and to the facility where the incident allegedly occurred within 24 hours of receiving the report.

(d): The PSA Compliance Manager reported that there have been no reports of incidents received from another facility of an allegation occurring at OCCJA-MDF during the audit period; however, in the event one is received, it would be reviewed first to see if the incident had already been reported and investigated and if not, it will be forwarded to the Director of Law Enforcement to initiate an investigation and notification will be made to the ICE ERO FOD.

§115.64 - Responder duties.

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

Notes:

(a)(b): Policy OCCJA/2.10 states, "upon learning of an allegation of sexual abuse, the first responder shall follow the appropriate procedures required: a) separate the victim and abuser; b) preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; c) if the abuse occurred within a time period that still allows for the collection of physical evidence, staff will request that the alleged victim not to take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating; d) if the abuse occurred within a time period that still allows for the collection of physical evidence, staff will ensure that the alleged abuse not take any action that could destroy physical evidence. If the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy evidence and then immediately notify security."

Interviews with security and non-security staff, confirmed that they are aware of their responsibilities as first responders. Staff responses to first responder protocols were consistent with the SAAPI training curriculum documented in 115.31 and facility policy. Based on review of the two allegations reported within the audit period, first responder protocols were initiated to the extent necessary based on the nature of the incident.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy OCCJA/2.10 states "the facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership." It further establishes that "the facility shall use a coordinated, multi-disciplinary team approach to responding to sexual abuse." The Director of Law Enforcement provided the Auditor with a Sexual Assault Coordination Plan between the Okmulgee County Family Resource Center, Okmulgee County Criminal Justice Authority, Muscogee Nation Family VPP, and Muscogee Nation Department of Health (DOH) SANE Program. This document is a coordination of services to be provided by community providers to a detainee who has been sexually assaulted. While these services are part of the coordination plan, it does not include the coordinated actions taken by staff first responders, medical and mental health practitioners, investigators, nor facility leadership in response to a sexual abuse incident. Based on the Auditor's interviews with staff, a review of policies, and a discussion of procedures with the PSA Compliance Manager, Director of Operations, and Director of Law Enforcement, it is evident that the coordinated actions for the multi-disciplinary team approach to responding to sexual abuse appear to be in place.

Does Not Meet (a): The facility does not have a written institutional plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The facility must develop a written institutional plan and provide the plan for compliance review.

(c)(d):Policy OCCJA/2.10 states that, "if a victim of sexual abuse is transferred between facilities covered by 6 CFR part 115, subpart a or b, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services. If a victim is transferred from a DHS Immigration Detention Facility to a facility not covered by 6 CFR part 115, subpart a or b, the sending facility shall, as permitted by law, inform the receiving facility the victim's potential need for medical or social services, unless the victim requests otherwise." The Auditor confirmed through interviews with the DON and nursing staff, that the receiving facility would be notified, in accordance with the requirements of this policy, if a sexual abuse victim transfers, although there have been no cases where a continuum of services upon transfer has been required. Based on interview with the Director of Operations and supported by written documentation, there were no victims of sexual abuse transferred to another facility during the audit period.

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

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

Notes:

Policy OCCJA/2.10 states, "staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation." The PSA Compliance Manager and Director of Operations, and Director of Law Enforcement all

confirmed that "any employee, contractor, or volunteer who is suspected of sexual abuse of a detainee would be removed from any further contact with detainees, pending the investigation outcome." Based on interview with the Director of Operations, there were no allegations made against staff, contractors, or volunteers within the audit period.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy OCCJA/2.10 prohibits staff, contractors, volunteers, and detainees from retaliating "against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity because of force, coercion, threats, or fear of force. The facility shall employ multiple protection measures, such as housing changes, removal of alleged staff abusers from contact with victims, and emotional support services for detainees and employees who fear retaliation for reporting sexual abuse or for cooperating with investigations." Based on Policy OCCJA/2.10 and interviews with the PSA Compliance Manager and Director of Operations, "for at least 90 days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation or beyond if the initial monitoring indicates a continuing need." Further, this policy requires that "monitoring shall include detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignment of staff," which was further confirmed through interviews. Based on the interview with the PSA Compliance Manager, the facility contracts with a community mental health provider, where both detainees and employees, who fear retaliation, may receive emotional support services. The interview with Director of Operations confirmed the facility's zero-tolerance for retaliation and suspicions of retaliation will be investigated and dealt with promptly. He is listed as the designee charged with monitoring for possible retaliation per Policy OCCJA/2.10, but delegates the monitoring to be conducted by the PSA Compliance Manager. The Auditor's review of the investigation files for the two allegations reported within the audit period, contained no documentation that retaliation monitoring occurred for either detainee. The PSA Compliance Manager advised that both of those cases occurred before she was assigned these duties and that she is aware of the requirement to monitoring retaliation beginning on the date that the allegation is received and will ensure that retaliation monitoring is documented for any future allegations.

Does Not Meet (c): The facility could not provide documentation of retaliation monitoring for the two detainees who reported allegations within the audit period. The facility must conduct retaliation monitoring immediately following a report of sexual abuse to see if there are facts that may suggest possible retaliation by detainees or staff. The facility must develop a process to ensure retaliation monitoring is conducted and documented as soon as an allegation is reported, and must provide training to staff responsible for monitoring for retaliation. The facility must provide the process established, documented staff training, and two examples of retaliation monitoring completed (if available) for compliance review.

§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): According to interviews with the Director of Operations and the PSA Compliance Manager and a review of Policy OCCJA/2.10 "care is taken to place a victimized detainee in a supportive environment that represents the least restrictive housing option possible. Any use of segregated housing to protect a detainee who is alleged to have suffered sexual abuse is subject to the requirements of 115.43 and victims are not to be held for longer than five days in any type of administrative segregation except in highly unusual circumstances or at the request of the detainee. Any detainee who alleges that he has been sexually assaulted is offered immediate protection from the assailant and referred for a medical examination and/or clinical assessment for potential negative symptoms. If the detainee has an increased level of vulnerability due to sexual abuse, after reassessment, this must be taken into consideration to determine whether the detainee will be allowed to return to general population." The Director of Operations reported that no detainee was placed in protective custody as a victim of PREA during the audit period. The Auditor's review of the investigation files found no indication that neither victim was placed in segregation.

(d): Interviews with the Director of Operations and PSA Compliance Manager indicated the facility will notify the appropriate ICE FOD whenever a detainee victim has been placed in administrative segregation for more than 72 hours in accordance with OCCJA/2.10.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy OCCJA/2.10 states "all investigations into allegations of sexual abuse and sexual harassment will be done promptly, thoroughly, and objectively, including third-party and anonymous reports. After consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity, an allegation found to be substantiated will be investigated. If the allegation is found to be unsubstantiated, the facility shall review any available criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring date; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator." The two investigations reviewed were conducted promptly, thoroughly, and objectively; however, only the OPR investigator was specially trained. During interviews with the PSA Compliance Manager, the Director of Operations, and the Director of Law Enforcement it was explained to the Auditor that all allegations of sexual abuse and sexual harassment are first assessed for criminal activity and are referred by the facility to the Law Enforcement Division who will make the initial assessment and assign an investigator. The Law Enforcement Division will conduct both the criminal investigation (if applicable) and the administrative investigation and keep the PSA Compliance Manager and Director of Operations informed of the status of the case. The PSA Compliance Manager and her back-up are both specially trained sexual abuse investigators and may potentionally be actively involved in an administrative investigation in conjuction with the Law Enforcement Division. Both cases investigated within the audit period documented consultation with ICE OPR.

(c): Policy OCCJA/2.10 states "the facility shall develop written procedures for administrative investigations" but no written procedures were provided for review and, based on interviews, Policy OCCJA/2.10 is the directing policy, but no procedures are developed for the facility to follow. The PSA Compliance Manager and her back-up are both specially trained sexual abuse investigators and may potentionally be actively involved in an administrative investigation in conjuction with the Law Enforcement Division. The Law Enforcement Director explained that he will establish standards for the facility investigation process to include evidence collection, interviewing protocols, credibility assessments, and proper documentation of written reports regarding investigative facts and findings. These reports will be retained for as long as the alleged abuse is detained or employed by the agency or facility, plus five years, per policy. OCCJA/2.10 has been reviewed and approved by ICE AFOD 11/13/2020. No detainee, who alleges sexual abuse is required to submit to a polygraph, per policy, and interview with the Law Enforcement Director.

Neither of the allegations reported within the audit period warranted a criminal investigation. Due to the nature of the allegations, there was no evidence collection/preservation required.

Does Not Meet (c): The facility has not developed written procedures for administrative investigations, which should include the provisions listed in this subpart of the standard (c)1-2. The facility must develop written guidelines for administrative investigations that addresses all the provisions listed in this subpart and conduct training with staff on the written guidelines. These guidelines should dileneate the responsibilities of the facility investigator during an administrative investigation. The facility must provide the written guidelines and the documented staff training for compliance review.

(e): Policy OCCJA/2.10 states "the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation." Interviews with the Director of Law Enforcement, the PSA Compliance Manager, and the Director of Operations confirmed that an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. In both investigation files reviewed, the alleged victims were still at the facility at the time the investigations were completed and closed.

(f): Policy OCCJA/2.10 states "when outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." OCCJA has its own Law Enforcement Division, who has jurisdiction over criminal investigations at the facility. The Director of Law Enforcement explained that he would work closely with the PSA Compliance Manager to ensure she is kept updated on the progress of any investigation.

Recommendation: The language used in OCCJA/2.10, VII.A.2 "After consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity, an allegation found to be substantiated will be investigated. If the allegation is found to be unsubstantiated, the facility shall review any available criminal investigation reports to determine whether and administrative investigation is necessary or appropriate.", is ambiguous and needs to be clarified.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Policy OCCJA/2.10 states that "the agency imposes standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse are substantiated." Upon review of the investigation files, the Auditor determined the administrative investigations demonstrated a preponderance of evidence in determining the disposition. The Director of Law Enforcement, who has specialized training in investigations, confirmed during his interview that he would review all cases investigated and would use no standard higher than preponderance of the evidence to substantiate an allegation.

§115.73 - Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Policy OCCJA/2.10 requires that "the facility notify detainees who allege sexual abuse either verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded following an investigation. All notifications to detainees described under this standard must be documented." The Auditor's review of the two investigation files found no indication that the detainees were notified of the disposition, or any actions taken. The facility provided an example of a notification that was made on 05/28/2020 for an investigation that was completed prior to the audit period. The interview with the PSA Compliance Manager indicated she is the designated person to make notifications, and that there have been no cases investigated/closed since she was assigned to this position.

Does Not Meet: The facility could not demonstrate that the detainees were notified of the investigative outcomes for the two investigations conducted during the audit period. The facility must ensure detainees are notified of the disposition and actions taken regarding their allegations and that documentation is retained of this notification. The facility must develop a process to ensure that all detainees are notified of the disposition and actions taken regarding their allegations and that documentation is retained of this notification and appropriate staff must be trained on the process. The facility must provide the process, documented staff training, and two examples of outcome notifications made to detainees (if available) for compliance review.

§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): Policy OCCJA/2.10 establishes that "any staff suspected of being involved in sexual abuse or assault will be removed from all duties involving detainee contact until pending investigation is completed and determination is made. Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. 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 section of sexual abuse of a detainee by a staff member, contractor, or volunteer." The Director of Operations confirmed during his interview that staff would be removed immediately pending investigation if suspected to have violated the PREA policies. The policy was reviewed and approved by the ICE FOD 11/13/20.

(c)(d): The Director of Operations confirmed during his interview, that "all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, as required by OCCJA/2.10." The facility reported there have been no incidents to demonstrate a need for termination, resignation, or other sanctions of a staff member for violating sexual abuse policies 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): Policy OCCJA/2.10 states "any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees and shall also be reported to law enforcement agencies unless the activity was clearly not criminal, and to relevant licensing bodies. If suspected of perpetrating sexual abuse, the facility will prohibit further contact with detainees by removing the contractor or volunteer from all duties pending the outcome of an investigation. The facility shall take remedial measures and shall consider whether to prohibit further contact with detainees by

contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within these standards." Based on interviews with the Director of Operations and the Volunteer Coordinator, the facility required no corrective actions for a contractor or volunteer during the audit period. Both explained during their interview that violations of the PREA policy would warrant removal.

§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): OCCJA/2.10 establishes "detainees are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in detainee-on-detainee sexual abuse. At all steps of the process, any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future." The facility has a disciplinary process which includes reviews, appeals, procedures and is provided to the detainees through the facility's detainee handbook. During interviews with the Director of Operations and the PSA Compliance Manager, they confirmed the facility's disciplinary process allows for progressive levels of reviews, appeals, procedures, and documentation procedures. The facility's disciplinary procedures are outlined in the facility's detainee handbook, which may be accessed by detainees through the kiosk, as confirmed by the Auditor.

(d): Policy OCCJA/2.10 states that "the disciplinary process shall consider whether a detainee's mental disabilities or mental illness contributed to such behavior, when determining the severity of the sanction." The PSA Compliance Manager confirmed during her interview that staff assistance is provided, if requested by the detainee, and is provided automatically, if the detainee is determined to be cognitively impaired, LEP, or otherwise needs special assistance. This was further confirmed through interviews with the case workers.

(e): "Detainees are disciplined for sexual conduct with staff only upon finding that the staff member did not consent to such contact", per Policy OCCJA/2.10. Interviews with the Director of Operations and the PSA Compliance Manager confirmed that a detainee would not be disciplined for sexual conduct with staff, if the investigation revealed the staff member consented or was the perpetrator. They also stated there have been no incidents of staff involvement with a detainee during the audit period.

(f): Policy OCCJ/2.10 further "prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation." No detainees have been disciplined for sexual abuse policy violations or for making a report in good faith during the audit period. The PSA Compliance Manager stated that a detainee would only be disciplined for making a report if the report was untrue and was made with malicious intent. The Auditor's review of the investigation files for the audit period, determined the allegations were either unfounded or unsubstantiated and no disciplinary action was taken against any detainee involved in the incident.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy OCCJA/2.10 requires that "if the assessment pursuant to 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and mental health follow-ups. When a referral for medical 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 is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after referral." The screening instrument, specifically question seven, asks directly if the detainee has been a victim of sexual abuse in the past. The form also contains a section for the nurse to indicate if the detainee is referred to mental health based on the results of the screening. The Auditor's interview with the DON determined that any services provided to detainees regarding sexual abuse history will be done by an external practitioner; the facility contracts with a local mental health provider for services. The facility reports that there have been no detainees who disclosed prior sexual abuse, either as victim or perpetrator, during the audit period. Interviews with staff who participate in the booking process confirmed that, when a detainee discloses prior sexual abuse, they are required to bring this to the attention of medical personnel, so they can offer the detainee a referral to mental health services. based on the interviews with the DON and other medical staff, medical staff conduct a medical assessment during the intake process, usually within the first two hours.,.

One detainee disclosed to the Auditor during his interview that he was a victim of sexual abuse prior to coming to the facility. The Auditor asked if he had reported this to facility staff upon arrival and he said he had not. The Auditor asked the detainee if he would like to speak with a professional to help him deal with his past trauma and he said yes. A referral to mental health services was made by the Auditor to the PSA Compliance Manager on 08/12/2021. The Auditor checked the status of the referral on 09/07/2021, and it was reported by the DON that the referral had been made, but the detainee had not been seen yet.

Does Not Meet (c): The facility has not demonstrated compliance with provision (c) which requires a referral for mental health follow-up to be conducted no later than 72 hours after the referral. A referral to mental health was made on 8/12/2021 and was not seen by mental health as of 9/7/2021 beyond the 72-hour requirement. The facility must develop a process to ensure detainees that disclose prior sexual victimization are referred and seen by mental health within 72 hours, and must conduct training with staff on the process. The facility must provide two examples of a detainee who has been referred and seen by medical and/or mental health within the appropriate time (if available) for compliance review.

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

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

Notes:

(a)(b): Policy OCCJA/2.10 establishes "Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the even health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." Based on interviews with the Director of Operations and the DON, no detainee required emergency medical/mental health services for sexual abuse during the audit period. The Auditor's review of the two investigation files found that the alleged victim was seen by medical and/or mental health for an assessment on the date that the incident was reported, and with a follow-up the next day. Further, neither detainee required any testing or follow-up treatments.

§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): Policy OCCJA/2.10 establishes that the facility "offers medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while any prison, jail, lockup, or juvenile facility. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to, or placement in, other facilities or their release from custody. The facility shall provide such victims with medical and mental health services consistent with the community level of care." Interviews with the DON and nursing staff confirmed that medical and mental health evaluations, and treatment for detainees who have experienced sexual abuse, will be provided, consistent with community level of service. The DON stated that the mental health services would be provided through a contract with community provider, and medical services would be provided to the extent that they were able and would be provided by external providers should there be a need for services not available within their medical department.

(d): The facility does not house female detainees.

(e)(f): Policy OCCJA/2.10 establishes that "detainee victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Treatment services are 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 DON and nursing staff confirmed, during interviews, that treatment and tests for sexually transmitted infections will be initiated at the ER, but that follow-up orders would be carried out, or other indicated tests that are required, consistent with community care, will be offered. The DON and Director of Operations confirmed, during their interviews, that victims of sexual abuse are not changed for services resulting from the abuse.

(g): Policy OCCJA/2.10 states "the facility will maintain that a mental health evaluation is conducted of all detainee-on-detainee abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners." Based on interviews with the PSA Compliance Manager and Director of Operations, and a review of the investigation files for the audit period, there have been no abusers identified. As noted, before, evaluations would be referred to the contract mental health provider.. The DON confirmed that the services are offered, but the detainee may decline.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy OCCJA/2.10 states "the facility conducts a sexual abuse incident review within 30 days at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The incident review team will include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health staff. The facility prepares a report of its findings from sexual abuse incident reviews, and any recommendations for improvement and submits a report to the facility head and PREA Coordinator. The facility will implement the recommendations or will document the reason for not doing so. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility." As confirmed through interviews with the Director of Operations, the PSA Compliance Manager, and a case manager who participated in an incident review, each incident is reviewed to see if there are any changes in policy or operations that may improve the SAAPI program. Based on the Auditor's review of the two closed investigation files for the audit period, only one of the files indicated an incident review had been completed within 30 days of the closure of the investigation and according to the requirements of this standard; no recommendations were made for improvements following this review. The Director of Operations indicated that all cases are reviewed at the conclusion of the investigation. The facility was unable to demonstrate that the incident review report and response was forwarded to the agency PSA Coordinator.

Does Not Meet (a): DHS requires an incident review after the conclusion of all investigations, to include unfounded cases. An incident review was conducted for only one of the two closed investigations. The facility was unable to provide any documentation where an incident review was conducted on the second case. The the policy should be updated to include the requirement for a review of unfounded cases. Additionally, the facility was unable to demonstrate that the incident review report and response was forwarded to the agency PSA Coordinator for either of the closed cases.

Recommendation: The one documented incident review did not include medical personnel; the Auditor recommends medical personnel be included on future incident reviews per protocol.

(c): Policy OCCJA/2.10 requires "an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, FOD or his/her designee, and the agency PSA Coordinator." Based on interview with the Director of Operations and written memorandum, the facility has not conducted an annual review for any sexual abuse allegation for the audit period.

Does Not Meet (c): The facility must conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. The results and findings of the annual review must be provided to the facility administrator, FOD or designee, and the agency PSA Coordinator. The facility must provide the annual review report of all sexual abuse investigations and provide documentation the report was provided to the facility administrator, FOD, and the PSA Coordinator for compliance review.

§115.87 - Data collection.

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

Notes:

(a): Policy OCCJA/2.10 establishes that "the facility shall maintain in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post release treatment, if necessary, and or counseling in accordance with these standards and applicable agency policies, and in accordance with established schedules." The PSA Compliance Manager explained that the OCCJA maintains collected sexual abuse data for at least 10 years after the date of initial collection. She further explained that she maintains the investigation files associated with allegations of sexual abuse in her office in a

locked cabinet. She stated that the only other person who has access to the key is the Director of Operations. The Auditor observed the location of these files and found them to be secured properly.

§115.201 - Scope of audits.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(d): The Auditor was allowed access to and observed all areas of the audited facility, where ICE detainees were housed and had access.

(e): Documentation was provided to the Auditor approximately three weeks before the on-site visit through ERAU SharePoint, during the on-site visit upon request, and after the on-site visit upon request.

(i): The Auditor was provided a private office to conduct interviews with staff; detainee interviews were conducted privately in the visitation area.

(j): The interview with the PSA Compliance Manager confirmed that detainees would be allowed to mail the Auditor confidential correspondence. The audit notices were posted on each housing unit and in common areas, to include the booking area. No correspondence was received from detainees, staff, or other individuals.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	21
Number of standards not met:	16
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.

Sharon Ray Shaver 10/27/2021
Auditor's Signature & Date

(b) (6), (b) (7)(C) 10/27/2021
Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 10/27/2021
PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Sharon R. Shaver	**Organization:**	Creative Corrections, LLC.
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Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-579-[redacted]
AGENCY INFORMATION			
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FIELD OFFICE INFORMATION			
Name of Field Office:	Dallas		
Field Office Director:	Mark Moore		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	8101 N. Stemmons Frwy, Dallas, TX		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Okmulgee County Criminal Justice Authority – Moore Detention Facility		
Physical address:	111 S. Alabama Ave, Okmulgee, OK		
Mailing address: *(if different from above)*			
Telephone number:	918-938-0725		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director of Operations
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	918-520-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Coordinator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	918-650-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Okmulgee County Criminal Justice Authority – Moore Detention Facility, a.k.a. Okmulgee County Jail (OCCJA-MDF) was conducted August 10-12, 2021, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Sharon Shaver, employed by Creative Corrections, LLC. This is the first DHS Immigration Customs Enforcement (ICE) PREA audit of the facility. 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 ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The audit period was August 2020 through August 12, 2021.

During the audit, the Auditor found the OCCJA-MDF met 21 standards, had 2 standards (§115.31; §115.32) that exceeded, had 2 standards (§115.14; §115.18) that were non-applicable, and 16 non-compliant standards (§115.15; §115.16; §115.17; §115.21; §115.33; §115.35; §115.41; §115.43; §115.51; §115.52; §115.65; §115.67; §115.71; §115.73; §115.81; §115.86).

As a result of the facility being out of compliance with 16 standards, the OCCJA-MDF entered into a 180-day corrective action period which began on October 29, 2021, and ended April 26, 2022. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance. The Auditor was provided the initial ICE PREA CAP form for review on November 5, 2021. During the CAP period, the facility provided supporting documentation in response to the CAP, that was reviewed by the Auditor on February 17, 2022, March 9, 2022, April 11, 2022, and April 26, 2022. After the Auditor's final review on April 26, 2022, it was determined that the facility had completed the CAP and achieved compliance with the standards previously found out of compliance. The compliance determination for these standards is listed below.

Number of Standards Exceeded: 1

§115.35 Specialized training: Medical and Mental Health care

Number of Standards Met: 15

§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient (LEP)
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.71 Criminal and Administrative Investigations
§115.73 Reporting to detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews

PROVISIONS

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

§115. 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:

(d)(f): Policy 2.10 states "all cross-gender strip searches and cross-gender visual body cavity searches shall be documented and all cross-gender pat-down searches of female detainees shall be documented." The policy does not impose a requirement for cross-gender pat-down searches of male detainees to be documented, yet provision (d) requires all cross-gender pat-down searches to be documented. The facility provided a blank form DHS/ICE, G-1025 "Record of Search Form," which would be used in the event an opposite-gender search is conducted. There were no documented opposite gender searches of any kind for the audit period. Staff interviews confirmed that no opposite-gender strip searches or visual body cavity searches have been conducted. Staff interviews indicated staff are unaware that opposite-gender pat searches must be documented.

Does Not Meet (d): The facility does not require cross-gender pat searches of male detainees to be documented. The facility must implement a system for documenting cross-gender pat searches of male detainees and train staff on the requirement to document cross-gender pat-searches of male detainees.

Corrective Action Taken (d): On February 17, 2022, the facility reported on the CAP that Policy 2.10, PREA, was changed to include "all cross-gender pat searches will be documented;" however, the policy was not presented for Auditor's review at that time. On March 9, 2022, Policy 2.10, PREA, was provided for the Auditor's review and the Auditor found that language was added to require documentation of all cross-gender pat searches of detainees. On April 8, 2022, the facility provided a revised PowerPoint Presentation titled, "Search Techniques," used for training staff to conduct searches. The PowerPoint was updated to include that all cross-gender searches must be documented. The facility also provided a sample of training records, "Cross-Gender, Transgender, and Intersex Searches," to indicate staff were trained on the new procedures. The facility has demonstrated compliance with 115.15 (d).

(g): Policy 2.10 directs that "detainees will be allowed to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera) or as otherwise appropriate in connection with a medical examination or monitored bowel movement". Interviews with security staff and with the Director of Nursing (DON) confirmed that male officers are assigned to provide observation of a detainee when on suicide watch or during a monitored bowel movement, and that no such occurrences have been necessary in the past 12 months. The PSA Compliance Manager provided the Auditor with a tour of the camera system to observe camera views, and "shade-outs" in shower and toilet areas. Policy 2.10 does not establish the requirement for opposite gender staff to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothes; however, the Auditor observed staff of the opposite gender making announcements upon entering the housing units, and staff confirmed during interviews that they are required to be made. Of the detainee interviews, 8 of 20 stated that the announcements are made, while the other 12 either stated they were not, or that they were not sure if they were made.

Does Not Meet (g): The facility's policy does not include the requirement for opposite gender staff to announce their presence. The policy and procedure must require staff of the opposite gender to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothes. The facility must update the policy to address the standard language with procedural direction for staff and train staff on the updated policy. The facility must provide the updated policy with documented staff training on the policy for compliance review.

Corrective Action Taken (g): On March 9, 2022, the facility provided Policy 2.10, PREA, which was updated to require cross-gender announcements when an officer of the opposite gender enters a detainees housing unit; however, this requirement should be imposed upon all staff of opposite gender, not just officers. On April 11, 2022, Policy 2.10, PREA, was presented again for review and the Auditor found that language was added to require opposite gender announcements when a staff member of the opposite gender enters a detainee housing unit. Training records were provided at that time, but the records did not include the topic of opposite gender announcements.

On April 26, 2022, the facility provided a memorandum documented with signatures from 10 staff members indicating they received 115.15 Limits to cross-gender viewing "Knock and Announce Training" as of April 11, 2022. After review of this signed training acknowledgement and the revisions to Policy 2.10 previously noted, the Auditor finds the facility has demonstrated compliance with subpart (g) of this standard.

(j): Policy 2.10 states, "the agency shall train security staff in proper procedures for conducting pat-down searches, including cross-gender pat-downs and searches of transgender and intersex detainees. All pat-down searches shall be conducted in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety." The Training Coordinator confirmed during his interview that he trains all staff on how to conduct a proper, respectful, and professional search. The Auditor reviewed the lesson plan for Search Techniques and found it inconsistent with the facility's policy on searches. The lesson plan states, "if there is not an officer of the same gender as the inmate immediately available, the officer may go ahead with the search." The lesson plan does not explain exigent circumstances, nor does it explain that opposite-gender searches must be documented. In addition, the training presentation does not include any instruction on searches of transgender and intersex detainees. Records were provided for 18 officers who attended training on March 9, 2021.

Does Not Meet (j): The facility's training curriculum does not include instructions for transgender/intersex searches, nor does it explain exigent circumstances for opposite gender searches and the requirement to document these searches. The facility must train security staff in proper procedures for conducting searches of transgender and intersex detainees in a professional and respectful manner and in the least intrusive manner possible consistent with security needs and agency policy, including consideration of officer safety. The facility must provide the training curriculum for transgender and intersex pat-down searches and documentation of staff training for compliance review.

Corrective Action Taken (j): The Auditor reviewed the PowerPoint Presentation titled "Search Techniques," used for training staff to conduct searches on February 17, 2022; March 9, 2022; and April 11, 2022 and found that it did not include the required language of subpart (j) for compliance. On April 26, 2022, the facility provided a link for the Auditor to access a video from the National PREA Resource Center (PRC) website created by the Moss Group, Inc. titled, "Guidance in Cross-Gender and Transgender Pat Searches," and indicated that this video is utilized as part of the training curriculum. This video constitutes search training that complies with the requirements of subpart (j) of this standard. The facility previously provided a sample of three signed training acknowledgement forms as a sample indicating staff received additional training on the proper techniques for conducting Cross-Gender and transgender/intersex searches. Based on review of this video and the training records provided, the facility has demonstrated compliance with subpart (j) of this standard.

§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): Policy 2.10 establishes that "procedures have been established to provide disabled detainees equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment." These procedures include detainee educational materials being in "formats accessible to all detainees in accordance with Title II of the Americans with Disabilities Act, 42 U.S.C.". The policy specifies that "interpreter services will be provided for deaf or hard of hearing detainees; interpreter services will be provided for non-English-speaking detainees; staff will read the material to detainees." "The agency shall provide in person or telephonic interpretation services that enable effective, accurate, and impartial interpretation" per policy. The Auditor reviewed the facility's detainee handbook and found that detainees with a disability are advised they have a right to reasonable access to all programs, activities, and services available to other detainees; and the right to be provided aids or services to communicate, see, or hear. The facility's detainee handbook also includes the "I Speak… Language Identification Guide" and these guides are also posted in the housing units. Detainees may request interpretive services for essential communications by filling out a request form, from any facility or ICE officer. The facility provided a copy of the DHS Zero-Tolerance PREA poster in English and Spanish with the name of the PSA Compliance Manager. However, the posters displayed at the facility during the on-site visit did not have the name of the PSA Compliance Manager identified. The Auditor also made a recommendation to add these posters to the visitation area. While the facility's detainee handbook is published in English and Spanish, the facility did not have available any ICE National Detainee Handbooks in languages other than English and Spanish. Based on interviews with the PSA Compliance Manager and the Director of Operations, the facility's detainee handbook and the ICE National Detainee Handbook is made available to detainees through the kiosk in both English and Spanish. The Auditor attempted to access the ICE National Detainee Handbook through the kiosk with the assistance of a detainee unsuccessfully. The PSA Compliance Manager was made aware and said she would look into the problem which was not resolved by the conclusion of the on-site visit. The facility stated they would obtain the electronic versions of the ICE National Detainee Handbook in the other languages and upload them to the kiosk. The ICE National Detainee Handbook is available in English, Spanish, Punjabi, Russian, Arabic, Chinese, French, Haitian Creole, Portuguese, Hindi, Romanian, Turkish, Bengali, and Vietnamese. Based on detainee interviews, it does not appear that the DHS-prescribed Sexual Abuse and Awareness Information

pamphlet is provided to each detainee. The pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. The pamphlet is incorporated into the facility's detainee handbook in English and Spanish; however, the detainee interviews indicated that none had received the facility's detainee handbook. As indicated above, interviews with the PSA Compliance Manager and the Director of Operations indicated detainees are not provided a hard copy of the handbook; rather, they can be accessed through the kiosk. There is a copy of the pamphlet for general access in each housing unit in English and Spanish only. Additionally, each housing unit had a poster of local organizations that assist detainee sexual abuse victims available in English, Spanish, and Punjabi.

There were no detainees at the facility during the on-site visit, who were identified as having a hearing, visual, or cognitive disability, to interview. The Auditor used Creative Correction's Language Line Services to interview 13 of the 20 detainees interviewed. Of the 13 interviewed, 10 detainees stated that they were provided an interpreter, either by phone or in person, during the intake process. Of the remaining three detainees, one detainee stated that staff attempted to provide an interpreter by phone, but the service could not connect them with anyone who spoke his language (Wolof) at that time. Interview with intake staff confirmed that several attempts had been made through their interpreter service, but the service was not able to find anyone who spoke that language. This detainee also told the Auditor that he could not read or write, so any written material would not be helpful. At the time of the audit, this detainee had not been provided the SAAPI information in a manner or format that he could understand. The Auditor referred this detainee to the PSA Compliance Manager for SAAPI education with the use of an interpreter. The files for the other two detainees did not indicate that an interpreter was used during intake. During interviews with the LEP detainees, the Auditor was told by 2 of the 13 detainees that they had received a copy of the ICE National Detainee Handbook and the others said they had not. Each detainee's file reviewed contained signed documentation that they received a handbook; however as noted above, the detainees are not actually given hard copies of the handbooks, rather they have to use the kiosk to access them, which are only available in English and Spanish. When asked if they received information on SAAPI, three detainees stated "yes," and that they saw the DHS PREA posters and watched the Detainee Orientation video. During the interview with the Director of Operations, he explained that each housing unit is equipped with a kiosk that is used for multiple purposes for detainees to access commissary items, communicate with the facility staff, and to access important facility communications such as the orientation materials and video. The remaining 10 detainees stated either they had not seen the video, or if they did, stated it was in English. Everyone, except the detainee who indicated that they could not read or write, was aware of the DHS PREA posters in the housing units.

The Director of Operations explained during his interview that Language Line Services is used by staff when there is a language barrier, but they do not keep a log of calls made. He stated that the facility has a nurse on staff that is bi-lingual (Spanish), and that staff frequently use mobile phone applications such as Google/Apple Translate to communicate with LEP detainees. Several staff members interviewed by the Auditor also mentioned that they utilize these applications.

Does Not Meet (b): The facility has not demonstrated compliance with provision (b) which requires the facility to ensure meaningful access to all aspects of the agency and facility's efforts to prevent, detect, and respond to sexual abuse with detainees who are LEP. While it appears that the facility is using interpreter services during the intake processing, it does not appear that SAAPI information is presented in a language of the detainee's understanding for those who speak/understand a language other than English and Spanish. The facility does not appear to be handing out the ICE National Detainee Handbook, which is available in 14 languages. Each detainee's file reviewed contained signed documentation that they received a handbook; however, the detainees are not actually given hard copies of the handbooks, rather, they have to use the kiosk to access them, which are only available in English and Spanish. The facility does not appear to be making available the Sexual Abuse and Awareness Information pamphlet to each detainee, which is available in 9 languages. The facility must provide meaningful access to all aspects of the agency and facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are LEP. The facility must develop a process to ensure that all LEP detainees receive SAAPI information in a language and manner they understand and receive the ICE National Detainee Handbook in a language they understand. The facility must ensure all LEP detainees receive meaningful access to SAPPI information including the issue of the ICE National Detainee Handbook in a language of their understanding. The Auditor requested the facility must provide documentation for five LEP (other than Spanish) detainees arriving after the audit period, showing they have received the SAAPI training, with the language and manner of delivery (interpreter, written, etc.) documented as well as the language the ICE National Detainee Handbook was provided to the detainee for compliance review.

Corrective Action Taken (b): The Auditor reviewed documentation provided on February 17, 2022, PREA/Video Detainee Checklist form, but the form provided did not lend any additional information for consideration and there was no space to indicate in what language the SAAPI material is presented to the detainee. On April 11, 2022, the facility provided examples of the PREA/Video Detainee Checklist form for 10 detainees who received orientation on April 4, 2022. The form was updated to include a field to identify the language spoken and an interpreter ID when used. The documentation indicated 2

of the 10 required the use of a Spanish interpreter; all others were noted as speaking both Spanish and English. The Auditor had requested documentation of detainees that speak languages other than Spanish or English, if available during the corrective action period; the facility explained that they had not received any detainees who are LEP (other than Spanish) during the CAP period, to date. A list of new intakes was provided to the Auditor and five detainees who may speak languages other than Spanish or English were selected for review. The facility's response to the Auditor's request for five detainee's records indicated that these detainees were booked prior to the implementation of the new intake form; therefore, the documentation would not contain the information needed to make a compliance determination. On March 28, 2022, the facility updated the form to identify language spoken, interpreter used, and ICE National Detainee Handbook acknowledgement. The facility explained they have had no LEP Non-Spanish detainee intakes since March 28, 2022. However, the facility provided additional documentation for 12 detainees, which included 1 English as a Second Language (ESL) detainee. The documentation provided acknowledged that they had received the MDC Handbook and the ICE National Detainee Handbook as further evidence of the new procedure, in addition to the detainee records previously provided. The forms also indicated the detainees had watched the Immigration and Detention Orientation Video and the PREA Video. Based on the review of the updated intake form and the detainee records reviewed on April 11, 2022, along with the new information provided by the facility plus the additional detainee record provided, the Auditor finds the facility has demonstrated compliance with this standard.

§115. 17 - Hiring and promotion decisions

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

Notes:

(a)(b)(c): Policy 2.10, "prohibits hiring or promoting anyone who may have direct contact with detainees and prohibits enlisting the services of any contractor who may have contact with detainees who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; or who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercions, 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 the activity described in this section." Per this policy, "incidents of sexual harassment will be considered in determining whether to hire or promote anyone or to enlist the services of any contractor who may have contact with detainees; and consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse."

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 Contractor Personnel Directive 6-8.0, requires anyone entering or remaining in government service, employee or contractor undergo a thorough background examination for suitability and retention. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in October 2020 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.

The Auditor requested through the OPR PSO Unit confirmation of background checks for three ICE employees who work at the facility. All three have a current background investigation completed based on the information provided by the PSO Unit. The Auditor reviewed nine employee personnel files and found evidence of background record checks for newly hired employees, but not for longer standing employees. The PSA Compliance Manager stated that previously the background checks were not being retained so there was no evidence that these had been conducted. Based on the Auditor's review of the OCCJA Applicant Questionnaire & Background Investigation Form, review of personnel records, and interview with the Director of Operations, the facility does not ask all applicants who may have contact with detainees directly about previous misconduct described in this standard, either in written applications or interviews for hiring or promotions and in interviews or written self-evaluations conducted as part of reviews of current employees. In addition, per the policy and interview with the Director of Operations, a criminal background check is completed before hiring any new employee who may have contact with detainees, which was confirmed through interview with the Director of Operations, although review of personnel files did not support compliance. Policy 2.10 states "criminal background records checks will be conducted by the Director of Operations or his/her designee on all current employees, volunteers, and contractors, who may have contact with detainees at least every five years." Although, the Director of Operations disclosed during his interview that the five-year background checks are not conducted, nor required to be conducted, because their facility is not an immigration-only detention facility. There was no documented evidence that prior institutional employers were contacted for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse, although during interviews the Auditor was told that it is done.

Does Not Meet (b): The facility does not ask staff, who may have contact with detainees directly, about previous misconduct described in this standard, neither in written applications or interviews for hiring or promotions, nor in interviews or written self-evaluations conducted as part of reviews of current employees. The facility must develop a process to ensure all staff who may have direct contact with detainees are questioned about previous misconduct described in this standard, either in written applications or interviews for hiring or promotions and in interviews or written self-evaluations conducted as part of reviews of current employees. The Auditor requested evidence of a procedure which should include a method that will document the asking of these questions. The Auditor requested five examples of documentation indicating these questions have been asked for compliance review. The facility must provide documentation the process is in practice for compliance review. In addition, the facility must document that prior institutional employers were contacted for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of an allegation of sexual abuse.

Corrective Action Taken (b): The facility advised the Auditor that all employees are questioned about previous sexual abuse during their initial interview; however, the Auditor's review on February 17, 2022, did not find any documented evidence that this has occurred. On March 9, 2022, the facility provided a memorandum stating all current employees have been asked about previous sexual misconduct; however, the facility did not provide any indication of the implementation of a procedure to ensure this is done for all new hires, for promotions, and in interviews or written self-evaluations conducted as part of reviews of current employees. Furthermore, the previous misconduct question asked of current employees, as listed on the memorandum, appears to include only those pertaining to "while at previous employers," and the standard is broader than this limited scope as stated in the memorandum. The Auditor has reviewed the facility's memorandum stating that prior employers in Oklahoma cannot divulge substantiated allegations of sexual abuse and requests the specific Oklahoma statute reference be added to support this assertion. Furthermore, sharing of this information should be permitted with the proper consent signed by the prior employee, which is not acknowledged by the facility.

On April 11, 2022, the facility provided an example of a completed OCCJA Interview Questionnaire. On this Questionnaire, #17 states "In previous employment have you ever had any sexual misconduct?" and #18 states "Have you ever been terminated from employment for sexual misconduct?" Neither of these questions fully satisfies the requirement in 115.17 subpart (b) to ask applicants directly about the misconduct described in subpart (a). The questions must include asking if the applicant has 1) "engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution;" 2) "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 3) "been civilly or administratively adjudicated to have engaged in such activity." As noted during the prior CAP review on March 9, 2022, there was still no indication of the implementation of a procedure to ensure this is done for all new hires, for promotions, and in interviews or written self-evaluations conducted as part of reviews of current employees. The procedure should include some method that will document the asking of these questions. The Auditor again requested five examples of documentation indicating these questions were asked for compliance review.

On April 26, 2022, the Auditor was advised that in addition to the previously provided attachment #5, Updated New Hire Questionnaire, reviewed by the Auditor on April 11, 2022, the facility implemented Attachment #24, Hiring and Promotions Checklist, for all hiring, promotions, and other in-house assignments. This form was provided for the Auditor's review and contains the necessary language to satisfy the requirement in 115.17 subpart (b) to ask applicants directly about the misconduct described in subpart (a) and captures the candidate's signature. The facility provided a written response that this form will be completed by all new applicants for employment and anyone who is applying for a promotion. Due to the implementation of Attachment #24 being within 15 days prior to the ending of the CAP period, the facility only had one sample of the form for review. In order to satisfy the requirement for these misconduct questions to be asked as part of reviews of current employees, the facility provided a written response that stated all current employees had been asked these misconduct questions. It was noted in the original interview with the Facility Administrator that the facility does not have a formal performance review of current employees, so there are no intervals for "written self-evaluations conducted as part of reviews of current employees" to coordinate implementation of Attachment #24; however, the facility does impose upon its employees a continuing affirmative duty to disclose any such misconduct. Additionally, during the Auditor's April 11 review, the facility provided a revised attachment #5 that also includes the three misconduct questions required in subpart (b) and includes an employment verification section to obtain information from a previous institutional employer related to substantiated allegations of sexual abuse and whether the candidate resigned during an investigation. Based on the Auditor's review of the updated forms, and the written responses provided, the facility has demonstrated compliance with subpart (b) of this standard.

Does Not Meet (c): Personnel files were missing documentation that background checks were conducted on all employees who may have contact with detainees; therefore, the Auditor was unable to confirm facility employees received a background check prior to having contact with detainees. The facility must conduct background checks on all employees

who may have conduct with detainees before hiring. The facility must develop a process to ensure backgrounds checks are conducted on all staff who may have contact with detainees prior to hiring. The facility must provide examples of background checks conducted prior to hiring for compliance review.

Corrective Action Taken (c): On March 9, 2022, the facility provided the criminal history background check for one employee; however, the Auditor requested five. Also, the Auditor needed additional information, specifically when the applicant applied/was hired, to validate that the check was done prior to the applicant being hired. The Auditor also required a process be developed to ensure these background checks are conducted prior to hiring and the facility did not provide a process at this time. On April 11, 2022, the facility provided OCCJA Pre-employment Background Check forms for five new employees indicating the date the background check was conducted and the hire date. The facility indicates that background checks will be conducted on everyone who has contact with detainees, and once conducted, are maintained in the employee's personnel file. The facility has demonstrated compliance with subpart (c) of 115.17, and the Auditor accepts this CAP as complete.

(d): Policy 2.10 further asserts that a criminal background check be completed before enlisting the services of any contractor who may have contact with detainees. Review of one contractor file found that background checks have not been completed on the contractor. Interviews with the Director of Operations and the PSA Compliance Manager further confirmed that although their policy indicated background checks would be performed on contractors before enlisting their services, they are not completed. Further outlined in the policy, "upon by request by the agency, the facility shall submit for the agency's approval written documentation showing the detailed elements of the facilities background check for each contractor and the facility's conclusions."

Does Not Meet (d): Background checks have not been completed on the mental health contractors who provide services for the facility. The facility must conduct background checks on all contractors who may have conduct with detainees before hiring. The facility must develop a process to ensure backgrounds checks are conducted on all contractors who may have conduct with detainees prior to hiring. The facility must provide five examples of background checks conducted prior to hiring of services for compliance review.

Corrective Action Taken (d): On March 9, 2022, the facility advised the Auditor that background checks will be done on everyone who has contact with detainees and a copy will be kept in a folder. As previously noted by the Auditor to the facility in the CAP document, "Corrective Action Required" section, the facility must develop a process to ensure backgrounds checks are conducted on all contractors who may have contact with detainees prior to hiring and provide to the Auditor for compliance review. The facility must conduct a background check on all current contractors (specifically the mental health contractors) and provide evidence of completion to the Auditor for compliance review. On April 11, 2022, the facility provided OCCJA Pre-employment Background Check forms for one contractor indicating the date the background check was conducted and the hire date. The Auditor requested five examples, but the facility had only one contractor to provide during the CAP. The facility indicates that background checks will be conducted on everyone who has contact with detainees, and once conducted, will be maintained in the contractor's file. The facility has demonstrated compliance with subpart (d) of 115.17.

§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): Based on Policy 2.10, the facility will "follow a uniform evidence protocol that minimizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions and shall be developed in coordination with DHS." While it has been established that an outside entity is responsible for conducting both administrative and criminal investigations, the PSA Compliance Manager and her back-up are both specially trained sexual abuse investigators and may potentially be actively involved in an administrative investigation in conjunction with the Law Enforcement Division. Therefore, the facility is required to develop evidence protocols as outlined in this standard. The Auditor reviewed the facility's evidence protocols and found protocols to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. However, the facility did not provide documentation the evidence protocols were developed in coordination with DHS.

The agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform 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 Enforcement and Removal Operations 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 the Inspector General (OIG), OPR, or the local law enforcement agency, the ICE AFOD would assign an administrative investigation to be conducted.

Does Not Meet (a): The facility did not provide documentation the evidence protocols were developed in coordination with DHS. The facility needs to document the coordination with DHS.

Corrective Action Taken (a): On February 17, 2022, the Auditor reviewed the Crime Scene SOP document provided by the facility for the evidence protocol; however, there is nothing to indicate that these protocols were developed in coordination with DHS, which is the basis of the non-compliance. Additionally, these protocols do not address the forensic medical examination or consideration of how best to utilize available community resources and services to address sexual assault victims' needs. On April 26, 2022, Policy 2.10 was provided to the Auditor for review and was updated with protocols that address the forensic medical examination and consideration of how best to utilize available community resources and services to address sexual assault victims' needs. The facility also provided a memorandum from the ERO Dallas AFOD, dated April 20, 2022, indicating the facility's policy 2.10 has been reviewed and approved, and that it was developed in coordination with the DHS ERO Dallas Management. The facility has demonstrated compliance with subpart (a) of this standard.

§115. 33 - Detainee education

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

Notes:

(a)(b): Policy 2.10 establishes that "all detainees, during intake, will receive orientation explaining the facility zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment." The policy further establishes that this orientation will include "prevention and intervention strategies; definitions of sexual abuse, and coercive sexual activities; explanations of methods for reporting sexual abuse; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including and explanation that reporting sexual abuse shall not negatively impact the immigration proceedings; and the right of a detainee who has be subjected to sexual abuse to receive treatment and counseling." Per policy, the "PREA education is available in accessible formats for all detainees including those who are LEP, deaf, visually impaired, otherwise disabled, or limited in their reading skills." There were no new intakes during the on-site visit for the Auditor to observe, but a simulation was provided. The Auditor reviewed the facility's orientation presentation "Moore Detention Facility Handbook Orientation" which is available in both English and Spanish and the only SAAPI reference in the orientation material is the statement "the facility has a zero tolerance for all forms of sexual abuse." Additionally, the Booking Officer required is to show the Detainee Orientation video as part of orientation. The Detainee Orientation video is a PowerPoint presentation that plays on the tv screen while detainees are being processed. There is one slide that presents the Sexual Abuse and Prevention/PREA zero-tolerance information; however, the orientation does not include prevention and intervention strategies; definitions of sexual abuse, and coercive sexual activities; explanations of methods for reporting sexual abuse; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including and explanation that reporting sexual abuse shall not negatively impact the immigration proceedings; and the right of a detainee who has be subjected to sexual abuse to receive treatment and counseling. Based on interviews with the PSA Compliance Manager and intake officers, this presentation plays on a loop and is presented in both English and Spanish. There is no formal orientation process where detainees are provided instruction. The Director of Operations explained that the video is installed on the kiosk and that each detainee must view the video, which documents through electronic signature their understanding before any other services is accessible to them through the kiosk. However, the video is only presented in English and Spanish, and not every detainee will have need to access the kiosk; therefore, some detainees may never see the video if they do not view it during processing or have a need to access the kiosk otherwise. The simulation and historical video of the intake procedures observed by the Auditor further confirmed that the facility is not providing all of the required information to detainees at intake. Based on the simulation, observation of historical video footage of a recent intake, and interviews with detainees, the facility has not demonstrated compliance with subparts (a) and (b) which requires the facility to provide instruction on the SAAPI program.

Based on interviews with the detainees and the information provided by the PSA Compliance Manager and Director of Operations, it appears that the facility is relying solely on the electronic information available on the kiosk and the television in the processing area to convey the SAAPI information to the detainee population. The facility did not have available any ICE National Detainee Handbooks in languages other than English and Spanish. Based on interviews with the PSA Compliance Manager and the Director of Operations, the facility handbook and the ICE National Detainee Handbook is made available to detainees through the kiosk in both English and Spanish. The Auditor attempted to access the ICE National Detainee Handbook through the kiosk with the assistance of a detainee unsuccessfully. Of the 20 detainees interviewed, only two stated they received an ICE National Detainee Handbook. The ICE National Detainee Handbook is available in English, Spanish, Punjabi, Russian, Arabic, Chinese, French, Haitian Creole, Portuguese, Hindi, Romanian, Turkish, Bengali, and Vietnamese. The DHS-prescribed Sexual Abuse and Assault Awareness pamphlet is incorporated into the facility's

detainee handbook in English and Spanish; however, the detainee interviews indicated that none had received the facility's detainee handbook. The pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi.

(c): Policy 2.10 requires the detainee "to sign documentation of participation in the PREA education sessions." The Auditor reviewed the detention files of the 20 detainees interviewed and observed a signed copy of the Moore Detention Center PREA/Video Detainee Checklist which indicates receipt of the facility's detainee handbook and ICE National Detainee Handbook, and Detainee Orientation video. Based on interviews with the PSA Compliance Manager and intake staff, detainee signatures are obtained on this checklist during the intake process, and not necessarily after all the information on the list is provided. The Auditor discussed the orientation procedures with the Director of Operations who further confirmed that the facility relies on the kiosk for delivery of the PREA education.

Does Not Meet (a)(b)(c): Based on the observed intake simulation, Detainee Orientation video, observation of historical video footage of a recent intake, and interviews with detainees, the facility has not demonstrated compliance with (a)(1-6) which requires the facility provide instruction on the SAAPI program. The orientation does not include prevention and intervention strategies; definitions of sexual abuse, and coercive sexual activities; explanations of methods for reporting sexual abuse; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including and explanation that reporting sexual abuse shall not negatively impact the immigration proceedings; and the right of a detainee who has be subjected to sexual abuse to receive treatment and counseling. The facility provides SAAPI training only in English and Spanish through the Detainee Orientation Video and the facility's Detainee Handbook. Further, SAAPI education is not provided to LEP detainees in a language and manner they can understand, and the ICE National Detainee Handbook is not provided to detainees. The facility must develop a detainee orientation program that covers all elements of this subpart, staff must be trained on the new orientation process, and the detainees must be provided SAAPI training to include prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. In addition, the SAAPI orientation program must be provided to all detainees in a manner of their understanding, so they have access to the full SAAPI program including the issuance of the ICE National Detainee Handbook in a language they understand. The facility must provide documentation demonstrating ten new intakes received the updated orientation program which must include all elements of subpart (a) for compliance review. The facility must also provide documentation demonstrating five new detainees who are LEP, in languages other than Spanish, were provided the updated orientation in a language of their understanding. The LEP detainee files should document the language the orientation was provided in and should include the language of the ICE National Detainee Handbook issued.

Corrective Action Taken (a)(b)(c): On March 9, 2022, the "Moore Detention Facility Handbook Orientation" PowerPoint was presented for review which included one slide (#25) on PREA and did not include prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse; staff-on-detainee sexual abuse and coercive sexual activity; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings. No new documentation was presented during this review to indicate the SAAPI orientation program is provided to all detainees in a manner of their understanding, so they have access to the full SAAPI program including the issuance of the ICE National Detainee Handbook in a language they understand. During the March 9, 2022, CAP document review, the Auditor responded to the facility with a request for a list of all detainees who were received into the facility between January 1 through March 1, 2022, in order to randomly select detainees for the document review. On April 11, 2022, the facility provided 10 examples of the PREA/Video Detainee Checklist form for 10 detainees who received orientation on April 4, 2022. It was determined during this review that the facility had updated this form on March 28, 2022, to include a field to identify the language spoken and an interpreter ID when used, along with receipt of the ICE National Detainee Handbook acknowledgement. The documentation indicated 2 of the 10 required the use of a Spanish interpreter; all others were noted as speaking Spanish and English. A list of new intakes was provided to the Auditor at that time and five detainees who may speak languages other than Spanish or English were selected for review. On April 26, the facility responded to the Auditor's request for these five detainee's records, at which time the facility indicated that these detainees were booked prior to the implementation of the new intake form; therefore, the documentation would not contain the information needed to make a compliance determination. However, the facility provided documentation for 12 additional detainees (English speaking) and 1 English as a Second Language (ESL) detainee who acknowledged that they received the MDC Handbook and the ICE National Detainee Handbook to further evidence the new procedures. The forms also indicated that they had watched the Immigration and Detention Orientation Video and the PREA Video. During this review, the facility explained they have had no LEP Non-Spanish detainee intakes since March 28, 2022. Based on the review of the updated intake form

and the detainee records reviewed previously on April 11, 2022, along with the new information provided by the facility plus the additional detainee record provided, the Auditor finds the facility has demonstrated compliance with subparts (a)(b)(c) of this standard.

(d)(f): Policy 2.10 states that "posters containing sexual assault awareness and reporting information are posted in the pre-booking and booking areas for detainees who make bond prior to being moved to population." The policy further establishes "that key information about the agency's PREA policies is continuously and readily available or visible through posters, 30-day comprehensive education, detainee handbooks, or other written formats. Policies material will be available in a language that detainees can comprehend." There is no documentation to support that a 30-day comprehensive education occurs. The Auditor observed the DHS-prescribed Sexual Assault Awareness notice posted in all housing units, but the name of the PSA Compliance Manager needed to be added. The detainee interviews further supported that these posters are readily available throughout the facility and the Auditors observed this information posted as described in all housing units and in common areas throughout the facility. The Auditor recommended a poster be added to the Visitation/Multi-Purpose Area. Of the 20 detainees interviewed, only 2 stated they received an ICE National Detainee Handbook (1-English/1-Spanish). The facility did not have the ICE National Detainee Handbook available in languages other than English and Spanish but requested the additional handbooks in PDF from ICE. The PSA Compliance Manager and the Director of Operations advised the Auditor that they would have the ICE National Detainee Handbook uploaded to the kiosk; however, this was not completed prior to the end of the on-site visit.

Does Not Meet (d)(f): Based on the Auditor's observations of the simulated intake, reviewed video intake, and interviews with staff and detainees, the facility is not providing the ICE National Detainee Handbook to detainees. The facility must develop a process to ensure all detainees receive the ICE National Detainee Handbook and ensure the handbook is provided in a language the detainee understands. The facility must provide the process, documented staff training on the requirement to issue the ICE National Detainee Handbook, and documentation of ten new LEP detainee intakes (at least five LEP detainees) receiving the ICE National Detainee Handbook for compliance review. The name of the PSA Compliance Manager must be listed on the DHS-prescribed sexual assault awareness notices posted at the facility.

Corrective Action Taken (d)(f): On April 11, 2022, the facility provided a photograph of the DHS-prescribed sexual assault awareness notice posted on the wall with the PSA Compliance Manager's name and number listed as the point of contact in response to the Auditor's recommendation during the initial CAP correspondence. The facility has demonstrated compliance with subpart (d) of 115.33. The facility also provided examples of the PREA/Video Detainee Checklist form for 10 detainees who received orientation on 04/04/2022. This form indicated that all detainees received a copy of the ICE National Detainee Handbook; 2 of the 10 in Spanish and the other 8 in English. A list of new intakes was provided to the Auditor and five detainees who may speak languages other than Spanish or English were selected for review and full compliance was pending review of those additional records. On April 26, 2022, the facility's response to the Auditor's request for five detainee's records indicated that the detainees, selected from the list provided, were booked prior to the implementation of the new intake form; therefore, the documentation would not contain the information needed to make a compliance determination. However, the facility provided documentation for 12 additional detainees (English speaking) and 1 English as a Second Language (ESL) detainee who acknowledged that they received the MDC Handbook and the National Detainee Handbook. They also indicated that they had watched the Immigration and Detention Orientation Video and the PREA Video. It was determined during Auditor's review on April 26 that the facility updated this form on March 28, 2022, to identify language spoken, interpreter used, and National Detainee Handbook acknowledgement. The facility explained they have had no LEP Non-Spanish detainee intakes since March 28, 2022. The facility also provided completed PREA/Video Detainee Checklist forms for an additional 12 detainees that were processed since the new form was implemented. Based on the review of the updated intake form and the detainee records previously reviewed on April 11, 2022, along with the new information provided by the facility plus the additional detainee records provided, the Auditor finds the facility has demonstrated compliance with this standard.

§115. 35 - Specialized training: Medical and mental health care
Outcome: Exceeds Standard (substantially exceeds requirement of standard)
Notes:

(c): Based on interviews with the Director of Operations, Director of Law Enforcement, and the DON, it was determined that the facility's medical staff does not conduct forensic examinations of sexual abuse victims; however, they may examine and provide treatment for any urgent medical issue to stabilize the detainee prior to being transported to the hospital for further treatment and examination. Mental health services are contracted out to a local community provider. The facility's medical staff and the mental health contractors have all received the basic training required in accordance with 115.31 and 115.32. The facility's policy and procedures were reviewed and approved by the ICE AFOD on 11/13/20. Policy 2.10 requires specialized training for medical and mental health care, but the facility's medical staff have not received specialized training.

Does Not Meet (c): The facility medical staff is required to have specialized training to include the following topics at a minimum: how to detect and assess signs of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; How and to whom to report allegations or suspicions of sexual abuse; and how to preserve physical evidence of sexual abuse. All facility medical staff and mental health care providers are required to complete this training and present training documentation/certificates for compliance review. The facility must provide specialized training with facility medical staff. The facility must provide documentation of specialized training with facility medical staff for compliance review.

Corrective Action Taken (c): On February 17, 2022, the facility provided certificates of completion for two medical staff for National Institute of Corrections (NIC) PREA training which included Behavioral Health Care for Sexual Assault Victims in a Confinement Setting; Medical Health Care for Sexual Assault Victims in a Confinement Setting; and PREA 201 for Medical and Mental Health Practitioners. The Auditor accepts this documentation for compliance with the requirements of subpart (c). The specific training modules taken by medical staff provides more than the basic requirement; therefore, the facility is found to exceed provision (c) of this standard and meets all other provisions of this standard in all material ways.

§115. 41 - Assessment or 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): Policy 2.10 directs "all detainees will be screened during intake and upon transfer to another facility using an objective instrument for their risk of being sexually abused by other detainees or sexually abusive toward other detainees in attempt to prevent such behavior. Each new arrival shall be kept separate from the general population until he is classified and may be housed accordingly." According to interviews with the intake staff, the PSA Compliance Manager, and the Director of Operations, detainees are held in the intake area until they are processed, classified, and screened, unless there is a large intake. In those cases, housing unit Z is used as a staging area where detainees are placed in two-person cells randomly and staff conduct the intake process in the common area of the housing unit. According to the interviews, these detainees are moved to appropriate room assignments once the risk screening is completed, and that no one is left assigned to that initial location beyond the booking period without a risk screening being completed. Also, per policy, "the intake screening and housing assignment will take place within 12 hours of arrival at the facility and with a reassessment of the detainee, by classification no later than 30 days from the detainee's arrival based upon any additional, relevant information received by the facility since the intake screening." All 20 detainee files reviewed indicated that the intake screening was conducted on the same date as their arrival. While there was no time stamps, staff and detainee interviews indicated the intake screenings were conducted within 12 hours. Additionally, there were no documented files indicating that a 30-day classification review was conducted. Based on interviews with the Director of Operations and the PSA Compliance Manager, there is no system in place for tracking high risk detainees. Without a system in place to track these detainees, the facility has not demonstrated their ability to keep separate likely abusers from detainees likely to be victimized.

Did Not Meet (a)(b): The facility has no system in place for tracking high risk detainees and has not demonstrated their ability to keep separate likely abusers from detainees likely to be victimized. The facility must develop a system to track detainees who are high risk for sexual abusiveness, and those who are at high risk for sexual victimization and present to the Auditor for compliance review. The Auditor was unable to confirm initial classification process and initial housing assignment for detainees were completed within twelve hours of their admission. The facility must develop a process to ensure these actions are completed within 12 hours of admission and provide 10 samples to the Auditor for review and determination of compliance with the 12-hour requirement.

Corrective Action Taken (a)(b): On March 9, 2022, the facility provided a document titled, "Inmate Head Count," which indicates a column for flags and included a flag for one detainee stating, "PREA Victim," which indicated that detainees at risk for victimization are now being tracked in the facility's offender management system. The facility did not provide any documentation that supported a process was developed to ensure the initial classification and initial housing assignment is completed within 12 hours of admission. The Auditor requested documentation of the process and 10 samples, completed after the date of the audit, for compliance review. On April 11, 2022, the facility provided screenshots from the facility's offender management system for 10 detainees which indicated the initial screenings are being conducted within 12 hours of arrival; additionally, the system triggers a flag for anyone who is identified as a potential victim or predator. Furthermore, an Inmate Head Count report was generated for these 10 detainees, to demonstrate how one of detainees who was flagged based on the screening results. The facility has demonstrated compliance with subparts (a)(b) of 115.41.

(e): Policy states "a detainee's risk level shall be reassessed between 60 to 90 days and when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the detainee's risk of sexual victimization or abusiveness." Of the 20 detainee files reviewed, 6 detainees had been at the facility for longer than 60 days, and each of these had a 60–90-day reassessment documented. Interviews with the PSA Compliance Manager and the Classification Coordinator confirmed that the detainee is tracked manually for the 60–90-day review, at which time a reassessment is conducted by classification staff and documented on the original screening instrument, on the second column as indicated.

This reassessment is conducted in-person with the detainee according to the Classification Coordinator. There was no documentation provided that indicated the detainees involved in the two reported allegations were reassessed after reporting the allegation at any time.

Does Not Meet (e): The facility does not complete reassessments on detainees involved in an incident of sexual abuse. According to the Performance-Based National Detention Standards (PBNDS) 2011, which the facility is contractually obligated to comply with, reassessments on alleged victims and abusers must be completed within 24 hours of an incident. The facility must develop a process to ensure all alleged victims and abusers are reassessed for risk of sexual victimization and abusiveness within 24 hours and staff must be trained on the process. The facility must document staff training of the process for compliance review. The facility must also provide two examples of detainees receiving reassessments based on an incident of sexual abuse or receipt of additional information within the required timeframe for compliance review.

Corrective Action Taken (e): On March 9, 2022, the Auditor reviewed the facility's policy 2.10 and found that "B. §115.42 Use of screening information B.1(a)" had not been revised since the Auditor's review during the initial audit phase. The language was not sufficient to ensure that a detainee's risk of victimization or abusiveness is reassessed following an incident of abuse or victimization. The Auditor was not presented with any documentation showing a new procedure, nor anything indicating staff were trained on a new procedure at this time. On April 11, 2022, Policy 2.10, PREA was presented for review and was revised to include language that requires the detainee to be reassessed due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the detainee's risk of sexual victimization of abusiveness. The facility stated they have had no allegations reported during the corrective action period; therefore, they did not have an example of a risk assessment conducted for that purpose. The facility also provided a signed attestation by the two staff who are responsible for conducting reassessments of detainees; this document acknowledged that they have received training on the updated policy about conducting a rescreening after an allegation of sexual abuse is received. Additionally, based on new guidance from ERO, the 24-hour requirement in the PBNDS-2011 does not apply to the reassessment required following an incident of abuse or victimization. Based on this new guidance and previous misinterpretation, this original finding related to the 24-hour requirement is no longer a deficiency. Based on the updated policy and the staff acknowledgement of the procedures, the facility has demonstrated compliance with subpart (e).

§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): Policy 2.10 establishes that "the facility will develop and follow written procedures governing the management of its administrative segregation unit and that the procedures will be developed in consultation with the ICE ERO FOD having jurisdiction for the facility. These procedures must document detailed reason for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault." Policy 2.11, Special Management Unit, governing the RHU/SMU, was provided for the Auditor's review but it did not contain the language necessary to comply with the requirements of this standard. Policy 2.10 states that "detainees at high risk for sexual victimization will not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers." The policy further states that "involuntary placement in administrative segregation shall not exceed 30 days. Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If the facility restricts access to programs, privileges, education, or work opportunities, the facility shall document the opportunities that have been limited, the duration of the limitation, and the reasons for such limitations." Based on interviews with the PSA Compliance Manager and the Director of Operations, administrative segregation would only be used as a last resort until alternative and appropriate housing could be determined and would never be over 30 days. The interviews further confirmed that a detainee placed in protective custody for this purpose would continue to have access to all services available to the general population. Based on correspondence from the Director of Operations and confirmed during his interview, the facility has not had any detainees placed in protective custody or administrative segregation regarding PREA in the audit period, which was further confirmed during the Auditor's interview with the SDDO. While the language stated within the 2.10 is consistent with the requirements of the standard, the facility has not demonstrated compliance with provision (a) which requires development of written procedures governing the management of its administrative segregation unit, in consultation with the ICE ERO FOD.

Does Not Meet (a): The facility has not developed written procedures governing the management of the administrative segregation unit, in consultation with the ICE ERO FOD, that include detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault, and that a supervisory staff member is required to conduct, at a minimum, a placement review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter. The facility must add the provisions of this subpart, developed in consultation with the ICE ERO FOD, to Policy 2.11, Special Management Unit, for compliance review.

Corrective Action Taken (a): On March 9, 2022, the Auditor reviewed policy 2.11 and found the policy section provided had not been revised since the Auditor's review during the initial audit phase. However, the facility explained that facility policy 2.10 PREA section C.2, 115.43 Protective Custody covers rules for placement for detainees at high risk for victimization, and C.4 covers supervisory review requirements; additionally, the facility does not place detainees in segregation based on a vulnerability to sexual abuse. The Auditor reviewed policy 2.10 and accepted this policy as the governing policy for placement for detainees at high risk for victimization, and C.4. as the procedures for review of vulnerable detainees placed in administrative segregation for their protection; both sections of this policy were found compliant with the requirements of the standard. However, although the Auditor accepted policy 2.10, at the time of this review, the facility did not provide the Auditor with evidence that the procedures were developed in consultation with the ICE ERO FOD. On April 11, 2022, the facility provided a memorandum dated November 13, 2020, from the AFOD to the facility stating that the Dallas Field Office has reviewed and approved the PREA Policy 2.10. The facility has demonstrated compliance with this 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): Detainees at the facility may privately report "sexual abuse, sexual harassment, or retaliation by other detainees or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents," per Policy OCCJA/2.10. The policy establishes the methods for reporting to include: "verbal reporting; grievance forms; request forms; call Rape Crisis Intervention Hotline at 877-756-2545 (non-recorded); write to Okmulgee County Family Resource Center at PO Box 73, Okmulgee, OK 74447; call National Sexual Abuse Hotline at 1-800-656-4673 (non-recorded line); ICE's Community and Detainee Hotline 1-888-351-4024 or #9116." The policy further explains that "detainees detained solely for civil immigration purposes must be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security." Numbers to the consular officials are provided on the Homeland Security Okmulgee County Jail (74447) publication and provided as free calls to all ICE detainees. This publication was observed in each housing unit and includes instructions on how to access the number pro-bono (without charge). The publication also advises detainees that anonymous calls may be made to the Detainee Reporting and Information Line (DRIL), JIC, or DHS OIG, and provides instructions for placing these calls. The Auditor, while accompanied by the PSA Compliance Manager, attempted to place a call, using the instructions for an anonymous call, from the detainee phones and was not able to complete the call using the instructions published for detainee use. The Auditor requested a test pin from the PSA Compliance Manager to place a test call to the other numbers listed for detainee reporting, but the facility was unable to provide a test pin. The telephone numbers should be tested prior to publishing instructions to ensure that the calls can be completed.

Does Not Meet (a): The telephone reporting methods accessible to the detainees that allow private, confidential, and anonymous reporting were not functionable. The Auditor was unable to place a test call from the facility without a PIN being entered. The facility must provide reporting methods to the detainees that are private, confidential and can be anonymous and instructions should be verified to ensure the calls can be completed. These calls should be accessible by detainees without requiring entering a PIN that would identify the detainee.

Corrective Action Taken (a): On April 7, 2022, the facility advised the Auditor that although the phone system requires the detainee to enter a pin, when the detainee dials the DRIL line or the national sexual abuse hotline, the call does not register as a call made from the detainee and the call is not recorded. In addition, detainees can report PREA concerns on the electronic kiosk directly to the facility PSA Compliance Manager; however, there was no documented evidence that supported this process as explained. On April 15, 2022, the facility advised the Auditor of their request through the phone provider that the national sexual abuse hotline and the DRIL hotline be made accessible without a PIN. Currently detainees must enter a PIN to utilize the facility phone system and to access the ICE Pro bono phone platform. Once a detainee accesses the ICE pro bono platform, they can contact the DRIL line and National Sexual Abuse Hotline without providing identifying information. On April 26, 2022, the facility provided the Auditor with additional information related to the ICE pro bono communication platform provided by Talton Communication. This platform provides detainees with the ability to make private, confidential, and anonymous phone calls to a public or private entity or office that is not part of the agency who have the capability to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous. The specific instructions provided to detainees and posted at all accessible phones and on the electronic kiosk located in each housing unit is as follows: "*For anonymous calls to CRISIS – Domestic & Sexual Abuse Hotline, DRIL – ICE Detention Reporting & Information Line, JIC – ICE Office of Professional Responsibility at Joint Intake Center, or DHS Office of Inspector General use 415 852 753 as A#.*" The DHS OIG and the CRISIS – Domestic & Sexual Abuse Hotline are both outside entities that are not a part of the agency or the facility. Once a detainee accesses the ICE pro bono platform, they can contact the DRIL line and National Sexual Abuse Hotline without providing identifying information. Based on the ability to place a call to the DRIL and National Sexual Abuse Hotline without providing identifying

information after accessing the ICE pro bono platform, and the instructions for placing a call in this manner by the phones and kiosk, the Auditor finds that the facility has demonstrated compliance with the requirements of this standard.

§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): Policy 2.10 establishes that the facility "has an administrative procedure for dealing with detainee grievances regarding sexual abuse and shall allow a detainee to file a grievance regarding an allegation at any time during, after, or in lieu of lodging an informal grievance or complaint. The detainee can submit a grievance at any time regardless of when the incident is alleged to have occurred. Facility staff shall present medical emergencies to the immediate attention of proper medical personnel for further assessment. Decisions on grievances filed regarding sexual abuse will be answered no later than 5 days and within 30 days of an appeal. All grievances relating to sexual abuse including a response, with respect to such grievances, shall be sent to the appropriate ICE FOD at the end of the grievance process." Policy 2.10 states that "the facility shall have procedures on identifying and handling time sensitive grievances that involve immediate threat to detainee health, safety, or welfare related to sexual abuse," but does not detail those procedures.

Does Not Meet (c): The facility has not provided documentation to demonstrate full compliance with the standard. The facility reported that no sexual abuse/harassment grievances has been filed in the audit period. However, one of the two investigative files reviewed by the Auditor indicated that the source of the allegation was via grievance. The grievance was not provided to evaluate procedural compliance as requested by the Auditor. The facility must outline emergency grievance/threat response related to provision (c) in 2.10, section V.B.3. The facility must provide the grievance and any other grievances related to sexual abuse for compliance review.

Corrective Action Taken (c): On February 17, 2022, the facility provided Policy 2.10 which has been revised to outline the procedures the facility must follow when handling time sensitive grievances that involve immediate threat to detainee health, safety, or welfare related to sexual abuse. On March 9, 2022, the facility advised the Auditor that the allegation originally thought to have been reported through a grievance, was in fact, reported by the detainee to a medical staff person during a medical visit. Therefore, there is no grievance to provide the Auditor for review. Based on review of the updated policy and evaluation of the explanation provided, the Auditor finds the facility has demonstrated compliance with subpart (c).

§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): Policy 2.10 states, "the facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership." It further establishes that "the facility shall use a coordinated, multi-disciplinary team approach to responding to sexual abuse." The Director of Law Enforcement provided the Auditor with a Sexual Assault Coordination Plan between the Okmulgee County Family Resource Center, Okmulgee County Criminal Justice Authority, Muscogee Nation Family VPP, and Muscogee Nation Department of Health (DOH) SANE Program. This document is a coordination of services to be provided by community providers to a detainee who has been sexually assaulted. While these services are part of the coordination plan, it does not include the coordinated actions taken by staff first responders, medical and mental health practitioners, investigators, nor facility leadership in response to a sexual abuse incident. Based on the Auditor's interviews with staff, a review of policies, and a discussion of procedures with the PSA Compliance Manager, Director of Operations, and Director of Law Enforcement, it is evident that the coordinated actions for the multi-disciplinary team approach to responding to sexual abuse appear to be in place.

Does Not Meet (a): The facility does not have a written institutional plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The facility must develop a written institutional plan and provide the plan for compliance review.

Corrective Action Taken (a): On February 17, 2022, the Auditor reviewed the Coordinated Action Plan provided and accepted for partial compliance. The facility name and effective date of the response plan needed to be included to be compliant. On April 11, 2022, the facility provided a revised Coordinated Action Plan that includes the facility name and effective date. The facility has demonstrated compliance with this standard.

§115. 67 - Agency protection against retaliation
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): Policy 2.10 prohibits staff, contractors, volunteers, and detainees from retaliating "against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for

participating in sexual activity because of force, coercion, threats, or fear of force. The facility shall employ multiple protection measures, such as housing changes, removal of alleged staff abusers from contact with victims, and emotional support services for detainees and employees who fear retaliation for reporting sexual abuse or for cooperating with investigations." Based on Policy 2.10 and interviews with the PSA Compliance Manager and Director of Operations, "for at least 90 days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation or beyond if the initial monitoring indicates a continuing need." Further, this policy requires that "monitoring shall include detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignment of staff," which was further confirmed through interviews. Based on the interview with the PSA Compliance Manager, the facility contracts with a community mental health provider, where both detainees and employees, who fear retaliation, may receive emotional support services. The interview with Director of Operations confirmed the facility's zero-tolerance for retaliation and suspicions of retaliation will be investigated and dealt with promptly. He is listed as the designee charged with monitoring for possible retaliation per Policy 2.10 but delegates the monitoring to be conducted by the PSA Compliance Manager. The Auditor's review of the investigation files for the two allegations reported within the audit period, contained no documentation that retaliation monitoring occurred for either detainee. The PSA Compliance Manager advised that both of those cases occurred before she was assigned these duties and that she is aware of the requirement to monitoring retaliation beginning on the date that the allegation is received and will ensure that retaliation monitoring is documented for any future allegations.

Does Not Meet (c): The facility could not provide documentation of retaliation monitoring for the two detainees who reported allegations within the audit period. The facility must conduct retaliation monitoring immediately following a report of sexual abuse to see if there are facts that may suggest possible retaliation by detainees or staff. The facility must develop a process to ensure retaliation monitoring is conducted and documented as soon as an allegation is reported and must provide training to staff responsible for monitoring for retaliation. The facility must provide the process established, documented staff training, and two examples of retaliation monitoring completed (if available) for compliance review.

Corrective Action Taken (c): On March 9, 2022, the facility advised the Auditor that all PREA claims will be monitored for retaliation, but no documentation to support this was provided at that time. The staff training documentation provided was dated May 22, 2021, and the site visit was conducted August 10-12, 2021, which did not constitute "additional training" to ensure that the designated staff were retrained on the retaliation monitoring procedures. On April 11, 2022, the facility provided a signed attestation by the designated staff who are responsible for monitoring retaliation. This attestation indicates they have received additional training regarding PREA retaliation monitoring as of March 28, 2022. The facility states there have been no allegations during the corrective action period; therefore, no monitoring has been conducted to provide to the Auditor for review. Based on the acknowledgement of the procedures by the designated retaliation monitors, the facility has demonstrated compliance 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:

(c): Policy 2.10 states, "the facility shall develop written procedures for administrative investigations" but no written procedures were provided for review and based on interviews, Policy 2.10 is the directing policy, but no procedures are developed for the facility to follow. The PSA Compliance Manager and her back-up are both specially trained sexual abuse investigators and may potentially be actively involved in an administrative investigation in conjunction with the Law Enforcement Division. The Law Enforcement Director explained that he will establish standards for the facility investigation process to include evidence collection, interviewing protocols, credibility assessments, and proper documentation of written reports regarding investigative facts and findings. These reports will be retained for as long as the alleged abuse is detained or employed by the agency or facility, plus five years, per policy. Policy 2.10 has been reviewed and approved by ICE AFOD 11/13/2020. No detainee, who alleges sexual abuse is required to submit to a polygraph, per policy, and interview with the Law Enforcement Director. Neither of the allegations reported within the audit period warranted a criminal investigation. Due to the nature of the allegations, there was no evidence collection/preservation required.

Does Not Meet (c): The facility has not developed written procedures for administrative investigations, which should include the provisions listed in this subpart of the standard (c)1-2. The facility must develop written guidelines for administrative investigations that addresses all the provisions listed in this subpart and conduct training with staff on the written guidelines. These guidelines should delineate the responsibilities of the facility investigator during an administrative investigation. The facility must provide the written guidelines and the documented staff training for compliance review.

Corrective Action Taken (c): On March 9, 2022, the Auditor reviewed policy 2.10 provided by the facility and found the policy section presented is the same as reviewed by the Auditor during the initial audit phase. The Auditor accepts policy 2.10 PREA, section VII.A.4 as the facility's written procedures for administrative investigations. The Auditor requires documentation of retraining on the procedures outlined in policy 2.10 PREA, section VII.A.4 for Administrative

Investigations, by all designated facility investigators who conduct administrative investigations. In addition, the facility needs to provide the Auditor with evidence where the procedure delineates the responsibilities of the facility investigator during an administrative investigation. On April 8, 2022, the facility provided a signed attestation by the designated facility investigators, dated March 25, 2022, stating that they have received refresher training on criminal and administrative investigations. This partially satisfied this standard, but the written procedure (policy) still neglected to delineate the responsibilities of the facility investigator during an administrative investigation as noted in the Auditor's review on March 9, 2022. On April 26, 2022, the facility provided an updated policy 2.10, which included the responsibilities of the facility investigator during an administrative investigation. Based on the Auditor's review of this updated policy, the facility has demonstrated compliance with this standard.

§115. 73 - Reporting to detainees

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

Notes:

Policy 2.10 requires that "the facility notify detainees who allege sexual abuse either verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded following an investigation. All notifications to detainees described under this standard must be documented." The Auditor's review of the two investigation files found no indication that the detainees were notified of the disposition, or any actions taken. The facility provided an example of a notification that was made on 05/28/2020 for an investigation that was completed prior to the audit period. The interview with the PSA Compliance Manager indicated she is the designated person to make notifications, and that there have been no cases investigated/closed since she was assigned to this position.

Does Not Meet: The facility could not demonstrate that the detainees were notified of the investigative outcomes for the two investigations conducted during the audit period. The facility must ensure detainees are notified of the disposition and actions taken regarding their allegations and that documentation is retained of this notification. The facility must develop a process to ensure that all detainees are notified of the disposition and actions taken regarding their allegations and that documentation is retained of this notification and appropriate staff must be trained on the process. The facility must provide the process, documented staff training, and two examples of outcome notifications made to detainees (if available) for compliance review.

Corrective Action Taken: On March 9, 2022, the facility provided a memorandum stating that the two designated facility investigators have received PREA notification training. Since no new investigations have been conducted since the initial audit phase, the Auditor waives the requirement to provide two examples for review. The facility has demonstrated compliance with the provisions of this 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): Policy 2.10 requires that "if the assessment pursuant to 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and mental health follow-ups. When a referral for medical 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 is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after referral." The screening instrument, specifically question seven, asks directly if the detainee has been a victim of sexual abuse in the past. The form also contains a section for the nurse to indicate if the detainee is referred to mental health based on the results of the screening. The Auditor's interview with the DON determined that any services provided to detainees regarding sexual abuse history will be done by an external practitioner, the facility contracts with a local mental health provider for services. The facility reports that there have been no detainees who disclosed prior sexual abuse, either as victim or perpetrator, during the audit period. Interviews with staff who participate in the booking process confirmed that, when a detainee discloses prior sexual abuse, they are required to bring this to the attention of medical personnel, so they can offer the detainee a referral to mental health services. Based on the interviews with the DON and other medical staff, medical staff conduct a medical assessment during the intake process, usually within the first two hours.

One detainee disclosed to the Auditor during his interview that he was a victim of sexual abuse prior to coming to the facility. The Auditor asked if he had reported this to facility staff upon arrival and he said he had not. The Auditor asked the detainee if he would like to speak with a professional to help him deal with his past trauma and he said yes. A referral to mental health services was made by the Auditor to the PSA Compliance Manager on August 12, 2021. The Auditor checked the status of the referral on September 7, 2021, and it was reported by the DON that the referral had been made, but the detainee had not been seen yet.

Does Not Meet (c): The facility has not demonstrated compliance with provision (c) which requires a referral for mental health follow-up to be conducted no later than 72 hours after the referral. A referral to mental health was made on August 12, 2021, and the detainee was not seen by mental health as of September 7, 2021, which is beyond the 72-hour requirement. The facility must develop a process to ensure detainees that disclose prior sexual victimization are referred and seen by mental health within 72 hours and must conduct training with staff on the process. The facility must provide two examples of a detainee who has been referred and seen by medical and/or mental health within the appropriate time (if available) for compliance review.

Corrective Action Taken (c): The Auditor reviewed the documentation provided by the facility on March 9, 2022, but it was unresponsive to the deficiency. Based on the Corrective Action stated by the facility on this form and that there have been no detainees requiring a referral since the initial phase of the audit, the Auditor requested that the facility administrator provide a memorandum acknowledging the requirements of 115.81(c) and future adherence and provide documented acknowledgement of understanding these requirements by the facility's SART members. On April 11, 2022, the facility provided a signed attestation from the Director, Chief Nursing Officer, Investigator, and PSA Compliance Manager stating the requirements of this standard will be adhered to for future allegations of sexual abuse. As no allegations have been received during the corrective action period, the Auditor accepts the acknowledgement of the procedures as demonstration of compliance.

§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): Policy 2.10 states "the facility conducts a sexual abuse incident review within 30 days at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The incident review team will include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health staff. The facility prepares a report of its findings from sexual abuse incident reviews, and any recommendations for improvement and submits a report to the facility head and PREA Coordinator. The facility will implement the recommendations or will document the reason for not doing so. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility." As confirmed through interviews with the Director of Operations, the PSA Compliance Manager, and a case manager who participated in an incident review, each incident is reviewed to see if there are any changes in policy or operations that may improve the SAAPI program. Based on the Auditor's review of the two closed investigation files for the audit period, only one of the files indicated an incident review had been completed within 30 days of the closure of the investigation and according to the requirements of this standard; no recommendations were made for improvements following this review. The Director of Operations indicated that all cases are reviewed at the conclusion of the investigation. The facility was unable to demonstrate that the incident review report and response was forwarded to the agency PSA Coordinator.

Does Not Meet (a): DHS requires an incident review after the conclusion of all investigations, to include unfounded cases. An incident review was conducted for only one of the two closed investigations. The facility was unable to provide any documentation where an incident review was conducted on the second case. The policy should be updated to include the requirement for a review of unfounded cases. Additionally, the facility was unable to demonstrate that the incident review report and response was forwarded to the agency PSA Coordinator for either of the closed cases.

Corrective Action Taken (a): On March 9, 2022, the facility provided policy 2.10, which included revisions that the facility will conduct an incident review at the conclusion of every sexual abuse case, including unfounded cases. The facility still has an obligation to conduct the review of the case that did not previously include a review. This review should be conducted and documented. The facility also still has an obligation to forward the incident review reports and response to the agency's PSA Coordinator for these two previous cases. The Auditor requested documentation of evidence that the outstanding review was conducted, and that both reviews were submitted to the agency's PSA Coordinator. On April 11, 2022, the facility provided a completed Sexual Abuse or Assault Incident Review Form for the two allegations reported within the audit period, and evidence of notification to the FOD and ICE PSA Coordinator. The facility has demonstrated compliance with subpart (a).

(c): Policy 2.10 requires "an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, FOD or his/her designee, and the agency PSA Coordinator." Based on interview with the Director of Operations and written memorandum, the facility has not conducted an annual review for any sexual abuse allegation for the audit period.

Does Not Meet (c): The facility must conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. The results and findings of the annual review must be provided to the facility administrator, FOD or designee, and the agency PSA Coordinator. The facility must provide the annual review report of all sexual abuse investigations and provide documentation the report was provided to the facility administrator, FOD, and the PSA Coordinator for compliance review.

Corrective Action Taken (c): The Auditor's review of the CAP for this standard on March 9, 2022, found that the 2021 Annual Review was not provided; in addition to the required report, evidence should be provided to indicate the report was submitted to the facility administrator, FOD and ICE PSA Coordinator. On April 11, 2022, the facility provided a completed Facility Annual Sexual Abuse and Assault Report for 2021 and 2020 and emails indicating the reports were submitted to the ICE PSA Coordinator and FOD. The facility has demonstrated compliance with subpart (c).

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.

Sharon R. Shaver June 4, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) June 8, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) June 8, 2022
Program Manager's Signature & Date