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

Homeland Security

AUDITOR INFORMATION			
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PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	New York Field Office		
Field Office Director:	Kenneth Genalo		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	26 Federal Plaza, New York, NY 10924		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Orange County Jail		
Physical address:	110 Wells Farm Road, Goshen, NY 10924		
Mailing address: *(if different from above)*			
Telephone number:	845-291-4033		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Captain
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	845-291-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Captain
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	845-291-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found Orange County Jail (OCJ) met 17 standards, had 0 standards that exceeded, had 2 standards that were non-applicable, and had 22 non-compliant standards. As a result of the facility being out of compliance with 22 standards, the facility entered into a 180-day corrective action period which began on March 15, 2023, and ended on September 11, 2023. 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.

Number of Standards Initially Not Met: 22

§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.35 Specialized training: Medical and Mental Health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.53 Detainee access to outside confidential support services
§115.61 Staff reporting duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.71 Criminal and administrative investigations
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews

The facility submitted documentation, through the Agency, for the CAP on June 27, 2023, through September 11, 2023. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on September 11, 2023. In a review of the submitted documentation to demonstrate compliance with the deficient standards, the Auditor determined compliance with 20 of the standards, and found that 2 standards continued to be non-compliant based on submitted documentation or lack thereof.

Number of Standards Met: 20

§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.33 Detainee education
§115.35 Specialized training: Medical and Mental Health care
§115.41 Assessment for risk of victimization and abusiveness
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§115.61 Staff reporting duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.71 Criminal and administrative investigations
§115.86 Sexual abuse incident reviews

Number of Standards Not Met: 2

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

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. 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:

(a)(b)(c): A review of the facility PAQ indicated OCCF has a total of 334 staff that have recurring contact with detainees, which includes 283 security staff, (229 males and 54 females) and 25 medical staff and 7 mental health staff, which are contracted through Well Path. The remaining staff consists of support personnel in administration and contracted food service staff through Trinity Food Services. In addition, the facility has five full-time ICE staff employed at the facility. According to the PAQ, security line staff work in eight-hour shifts, which include the following hours 0700-1500, 0800-1600, 0100-1800 and 1500-2100. A review of the PAQ further confirms that not all hours of the day are covered by a shift; however, based on the on-site tour, the Auditor accepts that the facility inadvertently did not report the shift that covers 2100-0100. An interview with the facility Administrator confirmed staffing levels are maintained with the use of voluntary overtime when needed. During the on-site audit, the Auditor observed and confirmed staffing levels at the facility were adequate. The facility has a total of (b) (7)(E) strategically located throughout the facility. (b) (7)(E) can be saved for up to 60 days. The Auditor observed (b) (7)(E) while on-site. In addition, the Auditor observed the facility comprehensive supervision guidelines, which are stored and accessible to staff on the facility computer system. The guidelines had been updated in 2021 and 2022, indicating an annual review is occurring. In an interview with the Agency PSA Coordinator/SDDO the Auditor confirmed he reviews and approves the facility supervision guidelines on an annual basis. During an interview with the FA, it was indicated that in determining adequate levels of supervision and (b) (7)(E) the facility takes into consideration general accepted detention practices, any judicial finding of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incidents review reports, and any other relevant factors, including but not limited to the length of time detainees spend in OCCF's custody. However, the facility did not provide the Auditor with the facility staffing plan, and therefore, the Auditor could not confirm the existence of a staffing plan or that when determining adequate levels of detainee supervision or the need for video monitoring the facility considered all elements of subsection (c) of the standard.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. In an interview with the FA, it was indicated that in determining adequate levels of supervision and (b) (7)(E) the facility takes into consideration general accepted detention practices, any judicial finding of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incidents review reports, and any other relevant factors, including but not limited to the length of time detainees spend in OCCF's custody. However, the facility did not provide the Auditor with the facility staffing plan, and therefore, the Auditor could not confirm the existence of a staffing plan or that when determining adequate levels of detainee supervision or the need for video monitoring the facility considered all elements of subsection (c) of the standard. To become compliant the facility must develop and document a staffing plan which takes into consideration all elements required in subsection (c) of the standard.

Corrective Action Taken (c): The facility submitted a memo from the current Corrections Administrator to the Sheriff that confirms the facility reviewed the staffing plan and (b) (7)(E) considering all elements of subsection (c) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

(d): OCSO policy, Supervisor Rounds, states, "Sergeants assigned to housing areas will conduct a minimum of three (3) unannounced rounds of the units under their supervision during each shift. Shift Commander Rounds: All units and other areas of activity will be visited by a Shift Commander at least once a shift. During these unannounced rounds, the Shift Commander will observe conditions in all areas, inspect security and safety devices and practices, inspect all cells and review and sign logbooks. Log entries must be in red ink." A review of OCSO policy, Supervisor Rounds, confirms it does not require supervisors to identify and deter sexual abuse of detainees. In addition, OCSO policy, Supervisor Rounds, does not prohibit staff from alerting others when unannounced security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility. Interviews with supervisor staff indicated unannounced rounds are occurring at the facility. Each supervisor interviewed confirmed the rounds occur at different times of the day or night to ensure the detainees and staff cannot determine a pattern of when the rounds occur. The Auditor reviewed facility logbooks. Supervisor rounds were noted in red ink and appeared to be frequently conducted on random days and shifts. However, the Auditor could not differentiate between unannounced PREA security inspections from regular supervisory

rounds required as noted in OCSO policy. Security line staff and supervisors indicated the facility prohibits staff from alerting other staff that rounds are occurring.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. During the on-site tour, the Auditor reviewed facility logbooks. Supervisor rounds were noted in red ink and appeared to be frequently conducted on random days and shifts; however, the Auditor could not differentiate between unannounced PREA security inspections and regular supervisory rounds required by facility policy. To become compliant, the facility shall implement a procedure for security supervisors to conduct unannounced security inspections to deter sexual abuse from occurring. The procedure shall include requiring supervisors to document the unannounced security inspections in a way that will confirm unannounced security inspections are to identify and deter sexual abuse of detainees. Once the new procedure is implemented, the facility must submit documentation that all custody supervisory staff were trained on the procedure. The facility must submit to the Auditor facility logbooks for a period of one month during the corrective action plan (CAP) period to confirm the implementation of the new procedure.

Corrective Action Taken (d): The facility submitted an email to all supervisors that directs supervisors to identify and deter sexual abuse of detainees during unannounced security inspections. In addition, the facility provided a read receipt that confirms the information was disseminated. Based on clear direction given to supervisors by the facility administration the Auditor no longer required logbook entries for one month during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

§115. 15 - Limits to cross-gender viewing and searches
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(g): OCSO policy, SAAPI, states, "Staff of the opposite gender may not visually observe inmates/detainees while changing clothing or showering unless within the scope of their duties. Staff of the opposite gender must also announce their presence upon entering the inmates/detainee living areas." A review of OCSO policy, SAAPI, confirms it does not include verbiage that prohibits opposite gender staff from viewing detainees while performing bodily functions except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. During the on-site audit, the Auditor observed all shower areas in the male and female detainee housing units. In the male detainee units, the showers are single showers with doors and in the female units, the showers are single showers with shower curtains. Both the doors and the curtains allow detainees to shower without being seen by staff of the opposite gender. Each individual cell had a toilet area, positioned next to the cell door. The position of the toilet allows detainees to perform bodily functions without being seen by staff of the opposite gender. During formal and informal interviews with detainees, all detainees reported they can shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender. In addition, they all reported the housing unit staff will announce when staff of the opposite gender enters the housing unit. This was also directly observed by the Auditor during the on-site audit.

Does Not Meet (g): The facility is not in compliance with subsection (g) of this standard. A review of OCSO policy, SAAPI, confirms it does not include verbiage that prohibits opposite gender staff from viewing detainees while performing bodily functions except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. To become compliant, the facility must update OCSO policy, SAAPI, to include verbiage that prohibits opposite gender staff from viewing detainees while performing bodily functions except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Once updated, the facility must submit updated OCSO policy, SAAPI, to the Agency for review and approval.

Corrective Action Taken (g): The Auditor reviewed updated OCSO policy, SAAPI, and confirmed the updated OCSO policy, SAAPI, included verbiage prohibiting staff of the opposite gender from visually observing a detainee while changing clothing, showering, or using the toilet. The facility submitted an email from the facility to the Agency that confirms the facility submitted updated OCSO policy, SAAPI, to the Agency for review and approval. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (g) of the 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): OCSO policy, SAAPI, states, "In compliance with Federal law and DHS policy New York State Penal Law the facility takes reasonable steps to provide meaningful access to the facility's Sexual Abuse and Assault Prevention and Intervention Program for inmates/detainees with Limited English Proficiency (LEP). 1) The Orange County Correctional Facility makes available competent foreign language and sign language interpreters to ensure effective communication with

inmates/detainees with LEP and disabilities (e.g., inmates/detainees who are deaf, hard of hearing or blind and inmates/detainees with low vision) during all aspects of the facility's efforts to fulfill this zero-tolerance policy. 2) A list of interpreters is available on the facility computer system, Jail Public. Under no circumstances will an inmate be used as an interpreter. 3) The GTL telephone translation machine for the hearing impaired is stored in the Command One storage closet. 4) Any inmate documented as hearing impaired at time of admission will be permitted access to the GTL telephone translation machine. 5) To obtain accommodations for inmates/detainees with a disability, facility staff will contact their immediate Supervisor." During interviews, Intake and security line staff advised the Auditor that upon intake, detainees are provided a document entitled "Inmate Orientation" which contains information on sexual abuse/assault, including treatment and counseling, prevention/intervention, and reporting sexual abuse and self-protections. Security line staff and Intake staff, explained to the Auditor the steps that are taken to effectively communicate with LEP detainees when necessary, including utilizing Pacific Interpreters and a Language Line Solutions Company. Intake and security line staff further indicated that a talk-to-text telephone (TTY) system service through Global Tel Link is utilized to communicate with detainees who are deaf or hard of hearing. For detainees who are LEP, the document is read to them utilizing the language line or a staff interpreter. Intake staff stated if a detainee had limited reading skills or was speech, intellectually or psychiatrically impaired, they would communicate the information on the same level as the detainee, so that they could understand. In addition to the Inmate Orientation document, the detainee is issued a tablet that contains the Inmate Orientation document, as well as facility policies, the facility handbook, the ICE National Detainee Handbook and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet. However, the Auditor reviewed the tablet and confirmed all documents are available in English and Spanish only. During the on-site audit the facility obtained the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE: Spanish, English, Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets in the 15 most prevalent languages encountered by ICE: English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading all languages onto the detainee tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, the Auditor could not confirm detainee accessibility while on-site. The Auditor further observed the orientation video and confirmed it was accessible in English and Spanish only. The Auditor also observed the DHS-prescribed sexual assault awareness notice, in English and Spanish, located in the intake area. The Auditor interviewed four detainees who arrived at the facility during the on-site audit. Three LEP detainees confirmed they were read the Inmate Orientation document, two reported it was read by a staff member and one reported it was read with the use of the language line; however, the fourth detainee reported nothing was read to him and he just signed the form. During interviews with 16 additional detainees, two detainees reported they understood PREA, their rights, how to report an incident of sexual abuse. The other 14 detainees interviewed indicated they did not understand what PREA was, what zero-tolerance meant, their rights, or that they could report an incident of sexual abuse in ways that don't include reporting it to a staff member.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. All PREA information is located on the detainee tablets; however, except for the facility handbook, which is also available in French, the PREA related information is available in English and Spanish only. During the on-site audit the facility obtained the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE: Spanish, English, Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets in the 15 most prevalent languages encountered by ICE: English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading all languages onto the detainee tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, the Auditor could not confirm detainee accessibility while on-site. In addition, in interviews with 20 detainees it was confirmed that 14 detainees were not able to articulate the meaning of PREA, zero-tolerance, or ways to report an allegation of sexual abuse in ways other than to staff. To become compliant, the facility must implement a practice that ensures that all detainees can participate in or benefit from all aspects of the Agency's efforts to prevent, detect and respond to sexual abuse, including detainees who are LEP. In addition, the facility must provide all detainees access to the PREA information included in the facility handbook, ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet, in a manner they understand. Once implemented, all intake staff must receive documented training on the new practice. The facility must provide the Auditor with 15 detainee files consisting of detainees who speak a language other than English, Spanish, or French to confirm implementation of the new practice.

Corrective Action Taken (b): The facility provided the Auditor three photographs of detainee tablets which confirmed the facility has uploaded the 2021 ICE National Detainee Handbooks which include the 14 most prevalent languages encountered by ICE on the detainee tablets. The facility submitted a photograph that confirmed the DHS-prescribed SAA Information pamphlet is available in the facility Law Library in the 15 most prevalent languages encountered by ICE. The facility submitted a refresher email to all intake staff that confirms all intake staff have received training on the new practice

that ensures all detainees can participate in or benefit from all aspects of the Agency's efforts to prevent, detect, and respond to sexual abuse in a manner all detainees can understand. The facility submitted a memo that confirms the facility did not receive any detainees who speak a language other than English, Spanish, or French during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

(c): OCCF's SAAPI states, "Under no circumstances will an inmate be used as an interpreter." In interviews with security line staff and supervisors, it was confirmed that the facility would not utilize a detainee for interpretation under any circumstances.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. OCSO policy, SAAPI, requires "under no circumstances will an inmate be used as an interpreter." Interviews with security line staff and supervisors, confirmed that they would not use a detainee to interpret under any circumstances. To become compliant, the facility must implement a practice of allowing the use of another detainee in matters related to sexual abuse should the detainee express a preference for another detainee to provide interpretation and the Agency determines such interpretation is appropriate and consistent with DHS policy. In addition, the facility must train all security line staff and supervisors on the updated practice and provide training records to confirm the training was conducted during the CAP period. The facility must submit updated OCSO policy, SAAPI, to the Agency for review and approval.

Corrective Action Taken (c): The facility submitted updated OCSO policy, SAAPI, that confirms it allows for detainees to request other detainees to provide interpretation services in matters related to sexual abuse in exigent circumstances when approved by the Agency. The Auditor reviewed the updated OCSO policy, SAAPI, and accepted "exigent circumstances" to include when a detainee requests another detainee to provide interpretation services in matters related to sexual abuse. The facility submitted a memo to all staff that confirms staff have been trained on the updated practice to allow for detainees to request other detainees to provide interpretation services in matters related to sexual abuse in exigent circumstances when approved by the Agency. The facility submitted a read receipt that confirms the information was disseminated. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the 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)(d)(e): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." ICE Directive 6-7.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." During a training session in November 2021, and through review of the training documentation available on SharePoint, the Unit Chief of OPR PSO explained that all ICE staff having contact with detainees must clear a background investigation through PSO before hiring. The staff complete an Electronic Questionnaire for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE. The Auditor submitted five ICE staff to PSO to verify the background check process. ICE PSO confirmed the investigation status of all five ICE staff prior to hiring and every five years, thereafter, as required by the standard. OCSO policy, Personnel, states, "Each candidate for a position Sworn or Civilian within the Corrections Division shall be subjected to an extensive background investigation. This investigation shall include, but is not limited to, a Mental Hygiene check, Credit Bureau check, Criminal Background check, personal and business reference check, past employment; military check, any incidents of engaging in sexual abuse in the workplace or any jail, lock up, community confinement facility, juvenile facility or other institution, as defined in 42 U.S.C. 1977, or any resignation of a pending investigation of an allegation of sexual abuse shall be deemed disqualified from the position within the Corrections Division, has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse or has been civilly or administratively

adjudicated to have engaged in the activity described in paragraph of this section." OCSO policy, Personnel, further states, "The facility maintains a current, confidential personnel record on each employee. The NYS License Event Notification Service (LENS) and eJusticeNY continually monitors staff and contractors and alerts the Agency of any background status changes." OCSO policy, Security Clearances and Facility Access, states, "When a contractor hires a new employee, they must complete the Orange County Correctional Facility Notice of New Hire form, pedigree form and a Background Investigation Form. The contractor will then forward the form to Programs and the Security Captain. All contractor hires will be subject to a fingerprinting and criminal history background check before administrative approval is granted for access to the facility" and "all persons requesting to work as volunteers will be subject to a background check, to include the submission of fingerprints to the Investigations Unit and an interview with the Programs Sergeant prior to being registered. All findings from the Identification Unit and the Programs Sergeant will be forwarded to the Security Captain for review so a determination can be made as the facility access approval or denial." The Auditor reviewed the "Applicant Integrity Warning" form and confirmed perspective employees are required to read and sign the document which states, "Any evasive, misleading or untruthful statement given to any employee of the Orange County Sheriff's Office; or any failure to disclose and provide information; or any failure to follow instructions given to me by my background investigator or any other employee of the Orange County Sheriff's Office designated to give me instructions; or engaging in any other act that is evasive, misleading or untruthful in nature during the course of my background investigation may result in the termination of my background investigation and/or removal of my name from the eligibility list for failing to meet the required integrity thresholds." During an interview with HR staff, the Auditor confirmed all staff, contractors and volunteers undergo a background check prior to employment. All staff are entered into New York State Department of Criminal Justice LENS. Through LENS the facility is notified anytime the employee/contractor has police contact, and therefore, acts as a continuous background check for OCCF staff. Entry into the system remains active until such time as there is a separation of the parties. The Auditor reviewed the system and confirmed entry of the employee/contractor's name, date of birth, social security number, agency of employment, job title, date of entry and status (full-time, part-time, or inactive). During the file review of eight employees, the Auditor confirmed entries into the system were made prior to the employee/contractor hiring date. However, the Auditor's review of the personnel records, nor the HR staff interview, could not confirm that that facility imposed upon the employee a continuing duty to disclose misconduct related to sexual abuse. An interview with HR staff, confirmed that material omissions regarding misconduct or false information is grounds for disqualification, termination, or withdrawal of an offer of employment. In addition, the facility HR staff, indicated during the hiring process an interview panel will meet with the candidate. During this interview, the candidate is asked if they have ever worked in a correctional type setting; (If candidate answered yes to #1) have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution; have you ever 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 unbale to consent or refuse; have you been civilly or administratively disciplined for any type of sexual misconduct; and have you ever been accused or disciplined for incidents of sexual harassment. The Auditor reviewed files for eight employees that were hired at the facility during the audit period. Any Candidate that answered no to question one was not asked if they have ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution. One candidate reported previous correctional experience and was asked the question. The Auditor confirmed, by review of the employee's personnel file, that during the background process, the facility contacted the candidate's past employer to obtain information on substantiated allegations of sexual abuse or resignation during a pending investigation. In addition, the Auditor reviewed the application of a candidate for hire who failed to disclose previous sexual abuse during the hiring process and confirmed the facility immediately disqualified the candidate. According to HR staff, the facility has not had any staff promotions, during the audit period; however, they would be asked about any previous misconduct during the promotion interview.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. During employment interviews, the candidate is asked if they have ever worked in a correctional type setting; (If candidate answered yes to #1) have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution. If the candidate does not have previous correctional experience, the interview panel will not ask if they have ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution. (As defined in 42 U.S.C. 1997, an institution is a facility or institution which is owned, operated, or managed by, or provides services on behalf of any State or political subdivision of the state and which is for persons who are mentally ill, disabled or retarded or chronically ill or handicapped; a jail or prison or correctional facility; a pretrial detention facility.) In addition, the facility provided no documentation to indicate that the staff have a continuing duty to disclose misconduct related to sexual abuse. To become compliant, the facility shall implement a practice to ask all candidates all questions regardless of past correctional experience. The facility shall provide the Auditor with documentation that at least 10 candidates were asked all questions during the hiring interview. In addition, the facility shall implement a practice that requires staff acknowledgement of the continuing affirmative duty to report any misconduct involving sexual abuse and provide documentation of the employee's understanding of the implemented practice.

Corrective Action Taken (a)(b): The facility submitted updated PREA Employment Questionnaire that confirms it contains all elements required by subsections (a) and (b) of the standard. The facility submitted a memorandum to all staff reminding staff of their continuing duty to report an allegation of sexual misconduct. In addition, the facility submitted a read receipt that confirms the information was disseminated. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

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

(a)(b)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." OCSO policy, SAAPI, states, "A prompt, thorough, objective and fair investigation shall be conducted into all allegations, including third party and anonymous reports of sexual abuse or assault." OCSO policy, SAAPI, further states, "In cases that involve an ICE Detainee, the Corrections Administrator shall coordinate as necessary with the ICE Office of Professional Responsibility (OPR) and/or criminal investigative entities responsible for the investigation of the incident." A review of OCCF policy, SAAPI, confirms it does not require the documentation of all reports and referrals of allegations of sexual abuse be maintained for at least five years. In addition, OCSO policy, SAAPI, does not require that all incidents of sexual abuse be reported to the Joint Intake Center (JIC), the DHS Inspector General's Office (OIG), or the appropriate ICE FOD. The Interviews with the FA and the PSA Compliance Manager confirmed the facility will conduct an administrative investigation into all allegations of sexual abuse. If the allegation is criminal, the PSCO will conduct a criminal investigation. All allegations of sexual abuse are immediately reported to the SDDO and the Field Office Director. Interviews with Investigators confirmed all investigation reports and referrals are maintained in accordance with the standard.

Does Not Meet(a)(b)(e)(f): The facility is not in compliance with subsections (a), (b), (e), and (f) of the standard. The facility has established a protocol, OCSO policy, SAAPI, as required by subsection (a) of the standard; however, a review of OCSO policy, SAAPI, confirms it does not require the documentation of all reports and referrals of allegations of sexual abuse be maintained for at least five years or the requirement to notify the JIC, DHS OIG, or the appropriate FOD of any incidents of sexual abuse. Interviews with the FA and the facility PSA Compliance Manager indicated that all incidents of sexual abuse are reported to the SDDO and the Field Office Director; however, the subsections (e) and (f) require that the facility must ensure that all incidents are promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General. To become compliant, the facility shall develop and implement a reporting procedure that ensures that, in addition to reporting an incident of sexual abuse to ICE OPR, the facility will notify the JIC, ICE Office of Professional Responsibility or DHS OIG, and the appropriate ICE Field Office Director. In addition, the facility shall revise the facility protocol to include the requirement of documentation and maintenance, for at least five years, of all reports and referrals of allegations of sexual abuse. Once the revisions to the protocol have been made, the facility shall train all investigative staff on the updated protocol. Documentation of the revision and the training shall be provided to the Auditor. If applicable, the facility must provide the Auditor with all sexual abuse investigation files that occurred during the CAP period to confirm that the allegations have been referred to JIC, ICE OPR, the DHS OIG, and the appropriate ICE Field Office Director.

Corrective Action Taken (a)(b)(e)(f): The facility provided a facility protocol that confirms it includes all elements of subsections (a), (b), (e), and (f) of the standard. The facility submitted an email to all investigative staff that confirms all investigative staff have been trained on the updated protocol. In addition, the facility provided a read receipt that confirms the information was disseminated. The facility submitted an email that confirms there have been no reported allegations of sexual abuse that occurred during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), (e), and (f) of the standard.

(c): During the Auditor's review of the OCCF's website (https://www.orangecountygov.com/511/Corrections-Jail) it was confirmed that the website does include the OCSO policy, SAAPI; however, a review of OCSO policy, SAAPI confirms it is not compliant with the standard; and therefore, the uploaded policy on the website, is not compliant. The Auditor also reviewed the ICE website (https://www.ice.gov/prea) and confirmed the required Agency protocol is available.

Does not meet (c): The facility is not in compliance with subsection (c) of the standard. OCSO policy, SAAPI, is posted on the facility website; however, a review of OCSO policy, SAAPI, confirms it is not compliant with the requirements of the standard; and therefore, the uploaded policy on the website, is not compliant. To become compliant, the facility must post the updated OCSO policy, SAAPI, on the facility website.

Corrective Action Taken (c): The facility provided the link ICE-PREA-Investigations- (orangecountygov.com). The Auditor visited the website orangecountygov.com and confirmed when searching ICE PREA Investigations a document posted November 2017 was available. However, the Auditor searched ICE-PREA-Investigations- (orangecountygov.com) in the Google search engine and confirmed the protocol was available in the Document Center which included over 10,000 documents making it difficult for the general public to locate. Therefore, the Auditor recommends the updated protocol be posted in a manner more assessable to the general public. Upon review of all available documentation the Auditor now finds the facility in substantial compliance with subsection (c) of the standard.

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

(a)(b)(c): OCSO policy, SAAPI, states, "All facility staff receives Sexual Abuse and Assault Prevention training during the initial orientation course and an annual refresher course thereafter." OCSO policy, SAAPI, further states, "The facility PREA Coordinator and Training Unit Supervisor shall maintain documentation verifying employee, volunteer and contractor training." Training is documented with training Sign In-Sheets at the beginning of training and a PREA Acknowledgment at the end of training." The Auditor reviewed the PREA Acknowledgment and confirmed it includes a statement which states, "I fully understand my responsibilities and duties as it pertains to detection, prevention and reporting possible PREA incidents within the facility." The Auditor reviewed the facility PREA training curriculum and confirmed the curriculum includes the facility's zero tolerance policy, definitions and examples of prohibited and illegal sexual behaviors and procedures for reporting knowledge or suspicion of sexual abuse; however, the curriculum does not contain the Agency's zero tolerance policy, the right of detainees and staff to be free from sexual abuse and from retaliation for reporting on the examples of prohibited and illegal sexual behaviors, 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 lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees, 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. In an interview with the facility PSA Compliance Manager, it was indicated that staff are required to attend PREA training prior to their initial hire and every year thereafter. During interviews with security line staff, they were confident in discussing the facility zero-tolerance policy. They could articulate how detainees can report an allegation and their own reporting responsibilities; however, the security line staff struggled with articulating some of the signs of sexual abuse, communicating with transgender and intersex detainees in an effective and professional manner and knowledge of staff and detainees to be free from retaliation for reporting, or cooperating with an investigation into sexual abuse. The Auditor randomly selected 14 employees' files for review, 12 were staff hired during the audit period and two were staff employed at the facility prior to May 6, 2014. The Auditor confirmed each file contained a training Sign In-Sheet and the PREA Acknowledgment form with a staff signature. The Auditor also reviewed the ICE PREA employee training for five ICE employees, which contained all elements required by this standard; however, no documentation was provided to indicate that the five ICE employees attended the Agency training. Documentation was provided that confirmed all five ICE employees had attended the mandatory OCCF training; however, the OCCF training lacked all required elements of the standard.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. The facility training curriculum does not contain the required elements of the Agency's zero tolerance policy, the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on the examples of prohibited and illegal sexual behaviors, 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 lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees, 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. In addition, the Auditor reviewed the ICE PREA employee training for five ICE employees, which contained all elements required by this standard; however, no documentation was provided to indicate that the five ICE employees attended the Agency training. To become compliant, the facility shall revise the PREA training curriculum to include all elements of this standard. Once the curriculum has been revised, the facility shall ensure that all facility staff are trained on the updated curriculum. In addition, the facility must forward documentation of the training completed during the CAP period for 20 OCCF staff. The facility must document that the five ICE staff have received PREA training as required by the standard.

Corrective Action Taken (a): The facility provided training certificates that confirm the SDDO, and the additional four ICE staff, have completed the required PREA Training. The facility submitted ICE policy 11062.2 which is reviewed during PREA training, and the OCJ lesson plan. The Auditor reviewed the submitted documentation and confirmed ICE policy 11062.2 includes the Agency's zero-tolerance policy. The facility submitted PREA training curriculum SAAPI which confirms it includes prohibition against retaliation for reporting a sexual assault. The facility submitted the revised PREA Lesson Plan that confirms it requires staff to be cognizant with communicating with detainees who are lesbian, gay, bisexual, transgender, intersex, and gender non-confirming; however, the PREA Lesson plan does not include how to communicate with detainees who are lesbian, gay, bisexual, transgender, intersex, and gender non-conforming. The facility submitted an email to all Jail Sergeants, Jail Officers, and Jail Command staff that requires them to review the updated lesson plan; however, the standard requires all staff and contractor staff to receive training on how to effectively and professionally communicate with detainees who are lesbian, gay, bisexual, transgender, intersex, and gender non-conforming. Upon review of all submitted documentation, and the lack thereof, the Auditor continues to find the facility does not meet subsection (a) of the standard.

§115. 32 - Other training

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

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "The facility PREA Coordinator and Training Unit Supervisor shall maintain documentation verifying employee, volunteer and contractor training." According to an interview with the PSA Compliance Manager contractors attend training with facility staff. The Auditor observed the training curriculum, which is the same curriculum used to train the facility staff. The training includes the facility's zero tolerance policy regarding sexual abuse and informs the employee how to report such incidents; however, the training does not include the Agency's zero-tolerance policy. The facility provided to the Auditor sign in sheets for medical and mental health staff; however, medical, and mental health staff do not provide services on a non-reoccurring basis as defined by subpart (d) of the standard. According to the PAQ and an interview with the Volunteer Coordinator the facility does not have volunteers currently working in the facility. Therefore, no interviews were completed with volunteers.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. The Auditor reviewed the PREA training curriculum and confirmed that the training does not include the Agency's zero-tolerance policy regarding sexual abuse. To become compliant the facility shall revise the PREA Training Curriculum to include the Agency's zero tolerance policy. In addition, the facility shall train all contractors who provides services on a non-reoccurring basis to the facility utilizing the revised training curriculum and provide the Auditor documentation such training.

Corrective Action Taken (a): The facility submitted 12 signed training forms that confirm "other contractors" receive a copy of OCCF Civilian Orientation and Training Manual. The Auditor reviewed a copy of the Manual and confirmed it includes the facility's zero tolerance policy and how to report an incident of sexual abuse. In addition, the facility provided a copy of ICE policy 11062.2 which is included in the PREA training for "other contractors." The Auditor reviewed ICE policy 11062.2 and confirmed it includes the Agency's zero tolerance policy. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the 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)(c): OCSO policy, SAAPI, states, "Upon admission to the facility, all inmates/detainees shall be notified of the facility's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and inmate/detainee handbook and provided with information about the facility's Sexual Abuse and Assault Prevention and Intervention Program. Such information shall include, at a minimum: the facility's zero tolerance policy for all forms of sexual abuse or assault; the name of the facility PREA Coordinator, and information about how to contact him/her; prevention and intervention strategies; definitions and examples inmate-on-inmate sexual abuse, staff-on-inmate sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including the DHS/OIG and the ICE/OPR investigation processes for ICE detainees, and right of detainees to report an incident or allegation of sexual abuse, assault, or intimidation to any staff member at the facility and to ICE/DHS; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of an inmate/detainee, who has been subject to sexual abuse or assault, to receive treatment and counseling." Formal and informal interviews with Intake staff, in conjunction with Auditor observations of a video recording of the intake process, confirmed detainees are provided a document, Inmate Orientation. A review of the Inmate Orientation Document confirms it contains information on sexual abuse/assault, including treatment and counseling, prevention/intervention, reporting sexual abuse and self-protections during the intake process; however,

the document does not provide information on how to report an allegation of sexual abuse to the DHS OIG or the JIC. In addition, it does not inform the detainee of the Agency's zero-tolerance policy, that retaliation, including reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, is prohibited, or definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual abuse. Interviews with Intake staff further indicated, if detainees are LEP, visually impaired, have limited reading skills, or otherwise disabled, the staff will read the document to the detainees and will use the language line or a staff interpreter, if needed. If the detainee is deaf, he/she can read the document, and if not in the language they can understand, they will use the sign language line to communicate the information to the detainee. Intake staff stated if a detainee were intellectually or psychiatrically impaired, they would communicate the information on the same level as the detainee, so that they could understand. All detainees are requested to answer yes or no, indicating they understand each section of the Inmate Orientation and to document the receipt of the facility rulebook and the ICE National Detainee Handbook. The detainees are not given a copy of the Inmate Orientation; however, a blank copy is made continually available on the detainee tablets, in both English and Spanish. In addition, the facility handbook, available in English, Spanish, and French, the ICE National Detainee Handbook and DHS-prescribed Sexual Abuse and Assault (SAA) Information pamphlet, available in English and Spanish, are also continually available and can be accessed on the tablets. However, in addition to the ICE National Detainee Handbook not being available in the 12 of the 14 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets not being available in the 13 of the 15 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, during an interview with the disciplinary officer it was confirmed that should a detainee receive a misbehavior report, facility sanctions include, the confiscation of the detainee's tablet for up to seven days, thus, prohibiting them from having access the PREA information available on the detainee tablet. At intake, detainees are asked to sign the Inmate Orientation document and acknowledge that they have received a copy of the facility rulebook and the ICE National Detainee Handbook. The Inmate Orientation states, "Inmate did receive a copy of the Inmate Rulebook. Yes or no and includes the statement, "You will be issued a tablet which contains the most recent version of the facility rulebook and the National Detention Handbook." The Auditor interviewed 20 ICE detainees, which included 4 of the detainees, that had arrived at the facility the night prior to the interview. Each detainee was asked if they remembered receiving information about sexual abuse, such as how to stay safe or how to report an incident. Eleven detainees responded they did not receive this information and eight stated they did. One detainee interview could not be completed and therefore no response was indicated. The Auditor reviewed 15 detainee files. All 15 detainee files contained the Inmate Orientation document, which had been signed by each detainee on the day of the detainee's intake into the facility; however, the signed document did not confirm that the detainee received the Inmate Orientation document, or other provided PREA information in a manner that they could understand. During the on-site audit the facility obtained the ICE National Detainee Handbook in the additional 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets in the additional 13 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading all languages onto the detainee tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, the Auditor could not confirm detainee accessibility while on-site.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), (c), and (d) of the standard. During the intake process, detainees are not provided an Orientation program that provides the detainees information on how to report an allegation of sexual abuse to the DHS OIG or the JIC, Agency's zero-tolerance policy, that retaliation, including reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, is prohibited, or definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual abuse as required by the standard. The facility handbook, available in English, Spanish, and French, the ICE National Detainee Handbook, and DHS-prescribed SAA Information pamphlet, available in English and Spanish, are continually available and can be accessed on the tablets. However, in addition to the ICE National Detainee Handbook not being available in the 12 of the 14 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets not being available in the 13 of the 15 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, during an interview with the disciplinary officer it was confirmed that should a detainee receive a misbehavior report, facility sanctions include, the confiscation of the detainee's tablet for up to seven days, thus, prohibiting them from having access the PREA information available on the detainee tablet. A review of 15 detainee files contained the Inmate Orientation document, which had been signed by each detainee on the day of the detainee's intake into the facility; however, the signed document did not confirm that the detainee received the Inmate Orientation document, or other provided PREA information in a manner that they could understand. To become compliant, the facility must implement an intake orientation program that ensures that all detainees can participate in and benefit from all aspects of the Agency's efforts to prevent, detect and respond to sexual

abuse, including detainees who are LEP. In addition, the facility must provide all detainees access to the PREA information included in the ICE National Detainee Handbook, and a copy of the DHS-prescribed SAA Information pamphlet, in a manner they understand; and ensure that the access be available at all times in at least one constant means should the detainee's tablet be confiscated when sanctioned for breaking a facility rule. Once implemented, all intake staff must receive documented training on the new practice. In addition, the facility must provide the Auditor with 10 detainee files consisting of detainees who speak a language other than English, Spanish, or French to confirm the new process has been implemented.

Corrective Action Taken (a)(b)(c): The facility submitted 3 photographs of detainee tablets which confirmed the facility has uploaded the 2021 ICE National Detainee Handbooks which include the 14 most prevalent languages encountered by ICE on the detainee tablets. The facility submitted a photo that confirms the DHS-prescribed SAA Information pamphlet is available in the Law Library should a detainee's tablet be confiscated. The facility submitted an email that states, "The DHS-prescribed SAA Information pamphlets have "made it onto the tablets." The facility submitted documentation to confirm all intake staff received training on the new practice. In addition, the facility submitted a memo that confirms the facility did not receive any detainees who speak a language other than English, Spanish, or French during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), and (c) of the standard.

(d)(e)(f): During an interview with the SDDO, the Auditor confirmed the DHS-prescribed SAA Information pamphlet is available for the detainees on the detainee tablets; however, in Spanish and English only. During an interview with the disciplinary officer, it was confirmed that should a detainee receive a misbehavior report one sanction used by the facility is to confiscate the detainee's tablet for up to seven days, thus, prohibiting them from having access to the DHS-prescribed SAA Information pamphlet. During the on-site audit, the SDDO had obtained the DHS-prescribed SAA Information pamphlet in the 13 unavailable most prevalent languages encountered by ICE: Arabic, Bengali, Chinese, French, Vietnamese, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Turkish, and Ukrainian and the ICE National Detainee Handbook in the additional 12 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading the additional languages on the tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, detainee accessibility could not be confirmed. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice which included the name of PSA Compliance Manager, and the contact information for OCRCC in English and Spanish only, in the intake area; however, the notices were not observed posted on any of the housing unit bulletin boards. Informal interviews with facility security line staff, indicated, detainees are provided a tablet, prior to entering the housing unit; however, the standard requires the information be posted. The Auditor reviewed the ICE National Detainee Handbook and confirmed it contains information about reporting sexual abuse; however, the ICE National Detainee Handbook was only made available to the detainees in English and Spanish.

Does Not Meet (d)(e)(f): The facility is not in compliance with subsection (d), (e) and (f) of the standard. During the on-site audit, the Auditor did not observe the DHS-prescribed sexual assault awareness notice or the contact information for OCRCC posted on the bulletin boards in the housing units. The DHS-prescribed sexual assault awareness notice and contact information for OCRCC was located on the detainee tablet; however, the information was only accessible in English and Spanish. A review of the detainee tablet further confirmed that the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet were uploaded on the detainee tablets; however, in English and Spanish only. In an interview with the disciplinary officer, it was confirmed that should a detainee receive a misbehavior report one sanction used by the facility is to confiscate the detainee's tablet for up to seven days, thus, prohibiting them from having access to the DHS-prescribed SAA Information pamphlet. A review of 15 detainee files contained the Inmate Orientation document, which had been signed by each detainee on the day of the detainee's intake into the facility; however, the signed document did not confirm that the detainee received the Inmate Orientation document, or other provided PREA information in a manner that they could understand. To become compliant, the facility must provide the detainees, the DHS-prescribed SAA Information pamphlet in a manner all detainees can understand. In addition, the facility must provide the Auditor with documentation that confirms the DHS-prescribed SAA Information pamphlet, in the 15 most encountered languages by ICE, and the ICE National Detainee Handbook, in the 14 most encountered languages encountered by ICE, are available to all detainees either through the detainee tablet or by distribution; and, that should a detainee receive a misbehavior report the facility will not confiscate the detainee tablet, thus, prohibiting them from having access to the PREA information uploaded on the detainee tablet. The facility must provide the Auditor with 15 detainee files that include detainees who do not speak English, French, or Spanish to confirm that the required PREA information, and intake orientation, is provided to the detainee in a manner that he/she can understand.

Corrective Action Taken (d)(e)(f): The facility submitted 3 photographs of detainee tablets which confirmed the facility has uploaded the 2021 ICE National Detainee Handbooks which include the 14 most prevalent languages encountered by

ICE on the detainee tablets. The facility submitted a photo that confirms the DHS-prescribed SAA Information pamphlet is available in the Law Library should a detainee's tablet be confiscated. The facility submitted an email that states, "The DHS-prescribed SAA Information pamphlets have "made it onto the tablets." The facility submitted documentation to confirm all intake staff received training on the new practice. In addition, the facility submitted a memo that confirms the facility did not receive any detainees who speak a language other than English, Spanish, or French during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (d), (e) and (f) of the standard.

§115. 35 - Specialized training: Medical and mental health care

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

Notes:

(b)(c): OCSO policy, SAAPI, states, "All full and part-time medical and mental health care practitioners who work regularly in the facility shall receive specialized training in detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse, responding effectively to victims of sexual abuse and assault, and reporting allegations of suspicions of sexual abuse or assault." In an interview with the HSA, and Mental Health Director it was indicated that medical and mental health staff have received specialized training through WellPath. The HSA provided documentation to the Auditor that confirmed medical and mental health staff have received the offered specialized training; however, the Auditor was not provided the training curriculum, and therefore, could not confirm all elements required by the standard are included in the training. In an interview with the SDDO, the Auditor confirmed OCSO policy, SAAPI, has been submitted to the Agency for review and approval.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. The Auditor was able to confirm that medical and mental health staff have received specialized training through WellPath; however, the facility did not provide the training curriculum to the Auditor; and therefore, the Auditor could not confirm all elements required by the standard are included in the WellPath training received by medical and mental health staff. To become compliant, the facility shall provide the training curriculum for specialized medical and mental health training. If non-compliance is determined, the facility must revise the training curriculum to include all elements of the standard and provide documentation that all medical and mental health staff have been trained on the revised curriculum.

Corrective Action Taken (b): The facility provided the specialized training curriculum through WellPath that confirms the curriculum is compliant with subsection (b) of the standard. As the curriculum is compliant the Auditor does not require the facility provide documentation that confirms all medical and mental health staff have received the required training. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (b) of the standard.

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

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

Notes:

(a)(b)(c)(d): OCSO policy, SAAPI, states, "All inmates/detainees are screened upon arrival at the facility for potential risk of sexual victimization or sexual abusive behaviors and are housed to prevent sexual abuse or assault. In addition to the intake screening upon arrival all inmates will receive follow-up screenings by medical and mental health staff. Any department that finds an inmate to be a PREA risk will enter an alert in the Jail Management System and the facility Black Creek computer system. Any inmate found to be a PREA risk will be referred to Mental Health for a follow up." OCSO policy, SAAPI, further states, "Each new inmate/detainee is kept separate from the general population until he/she has been classified and may be housed according to such classification." OCSO policy, Classification, states, "ICE Detainees will be assigned housing based on the ICE Classification criteria. Detainees are classified by ICE Officials as follows: low, medium low, medium high or high." During formal and informal interviews with Intake staff, Classification staff, and the PSA Compliance Manager, the Auditor confirmed all new arrivals of ICE detainees are kept separate from the general population until they are classified, and housing can be determined. Each detainee is assessed utilizing the facility Sexual Violence/Risk Assessment Screening form. The initial intake screening to assess risk for sexual victimization is completed by intake staff. The facility Sexual Violence/Risk Assessment Screening form asks the following questions: does physical stature create a potential for victimization; under the age of 20 or over the age of 60; has the inmate/detainee been the victim of sexual abuse; has the inmate/detainee ever been attacked in a jail or prison by other inmates/detainees; does the inmate/detainee know anyone within this facility that would be a threat to their safety; is this the first incarceration; does the inmate/detainee appear to have any of the following conditions: mental health problems, physical disability, development disability; does the inmate/detainee self-report to be the following: homosexual, bisexual, transgender, intersex; during the screening does the inmate/detainee behave in any of the following manners: intimidated, nervous, timid, fearful, isolated or withdrawn; does the inmate/detainee view him/herself as being vulnerable to sexual assault in the facility; current charge of sexual assault; current charge of sexual abuse of a child or elderly person or any other sex offense. If the detainee score is

4 or higher the detainee is referred to mental health. Classification staff complete the risk for abusiveness portion of the assessment after the detainee has been assigned to a housing unit. The risk for abusiveness form includes the following questions: violent criminal history; previous convictions of sexual abuse of a child or elderly person or any other sex offenses; past OCCF institutional disciplinary history of prohibited sexual acts; pending sexual charges; prior history of mental illness, hostile relationships with inmates, attempts at self-injury, suicide or has been on suicide watch, mental or physical handicapping conditions, assaulting behavior with staff, history of detention or incarceration, criminal history past or present, present or past history of escape or attempt. If the detainee scores 4 or higher they are referred to mental health. During interviews with Classification staff and the facility PSA Compliance Manager, the Auditor confirmed ICE detainees are housed based on the classification level assigned by ICE. The Classification staff can override the classification if the detainee is at risk for suicide or Classification staff discovers additional criminal convictions, not considered by ICE. Classification staff further indicated, the results of the initial screening are not considered and would not change the detainee's classification level and that the initial classification of the detainee is completed within twenty-four hours. The Auditor reviewed 15 detainee files; each file contained the completed Sexual Violence/Risk Assessment Screening form. The Auditor determined the risk for victimization was completed at the time of the intake of the detainee, however; the Auditor was unable to determine if the risk for abusiveness was completed by the Classification staff within twelve hours of the intake, as the form does not provide a time of completion. The Auditor formally interviewed 20 ICE detainees. All but one detainee reported the only questions asked during intake, was their name and date of birth. The 19 detainees further indicated they were not asked about previous sexual abuse or if they identify as lesbian, gay, bisexual, transgender, or intersex.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. During interviews with Classification staff and the facility PSA Compliance Manager, the Auditor confirmed ICE detainees are housed based on the classification level assigned by ICE. The Classification staff further indicated they can override the classification if the detainee is at risk for suicide or they discover additional criminal convictions that had not been considered by ICE; however, the results of the initial risk screening are not considered and would not change the detainee classification level assigned previously by ICE. In addition, Classification staff indicated that the initial classification is completed within twenty-four hours. The Auditor reviewed 15 detainee files; each file contained the completed Sexual Violence/Risk Assessment Screening form completed at the time of intake; however, the Auditor was unable to determine if the risk for abusiveness was completed by the Classification staff within twelve hours of the intake, as the form does not provide a time of completion. The Auditor formally interviewed 20 ICE detainees. All but one detainee reported the only questions asked during intake, was their name and date of birth. To become compliant, the facility must implement a practice requiring the facility to consider the information obtained during the initial risk screening to ensure the necessary steps are taken to mitigate any dangers identified in the assessment when determining a detainee's initial housing. In addition, the implemented practice must include the requirement to complete the initial classification process within twelve hours of admission into the facility. The facility must submit documentation of all intake and classification staff on the updated process. The facility must also provide the Auditor with 10 detainee files to confirm that the information obtained during the initial risk screening to ensure the necessary steps are taken to mitigate any dangers identified in the assessment when determining a detainee's initial housing and that the initial classification was completed within twelve hours of admission.

Corrective Action Taken (a)(b): The facility submitted 10 detainee files that confirm they include all information gathered during the initial risk assessment by stating, "I have also reviewed any records available from the…initial screening and risk assessment" to determine housing. The facility submitted documentation that confirms all intake and classification staff have been trained on the standard's requirement to consider information gained from the initial risk assessment in determining housing. Upon review of all available documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

(e): OCSO policy, Classification, states, "All active files will be re-classified every 90 days or earlier, if necessary, in accordance with New Your State Commission of Correction Minimum Standards, §7013.9, §7003.2 and §7003.3. ICE detainees may request a reassessment of their classification 60 days after arrival at the facility." An interview with Classification staff confirmed a detainee 's risk for victimization or abusiveness is reassessed between 60-and-90 days from the date of the initial assessment, or earlier, if requested by the ICE detainee, or if additional information is received, such as following an incident of sexual abuse that would warrant a reassessment. The Auditor reviewed 15 randomly selected detainee files. In seven of the files, the reassessment occurred between 60-and-90 days, three files indicated that the assessment occurred after 90 days, and five files indicated the detainee had recently arrived at the facility and was not within the time frame to conduct the reassessment. In addition, the Auditor reviewed two investigations, and confirmed in one of the investigations the detainees (victim and alleged perpetrator) had left the facility prior to a reassessment and in the other investigation both detainees had received an assessment within 30 days of the alleged incident.

Does Not Meet: (e): The facility is not in compliance with subsection (e) of this standard. The Auditor reviewed 15 randomly selected detainee files. In seven of the files, the reassessment occurred within 90 days, three files indicated that the assessment occurred outside of the 90-day time frame and five files indicated the detainee had recently arrived at the facility and was not within the time frame to conduct the reassessment. To become compliant, the facility must ensure that each detainee's risk of victimization or abusiveness is reassessed between 60-and90 days from the date of the initial assessment. If applicable, the facility must provide the Auditor with 10 detainee files to confirm that the detainees were reassessed within 60-and-90 days of the initial assessment.

Corrective Action Taken (e): The facility provided the Auditor with 10 detainee files that confirmed the detainee's risk of victimization or abusiveness had been reassessed within the 60–90-day timeframe required by the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (e) of the standard.

(f): Interviews with Intake staff and Classification staff, indicated that if a detainee refused to answer, or not disclose, the requested information, the detainee would be placed on a one-on-one suicide watch and referred to mental health staff to ensure the safety of the detainee.

Does Not Meet (f): The facility is not in compliance with subsection (f) of the standard. An interview with Classification staff indicated that if a detainee refused to answer, or not disclose information, the detainee would be segregated and placed on a one-on-one suicide watch until seen by mental health staff. To become compliant, the facility must develop and implement a procedure to ensure detainees are not disciplined by placing them in a segregated one-on-one suicide watch for refusing to answer questions asked during the intake screening. Once the procedure is established, the facility shall train all Intake and Classification staff on the established procedure. Documentation of the development of the procedure and training of the Intake and Classification staff shall be forwarded to the Auditor. If applicable the facility shall provide the Auditor with any detainee files that include a detainee who refused to answer questions asked during the intake screening to confirm implementation of the new process.

Corrective Action Taken (f): The facility submitted PREA training PowerPoint slides (slides 34 and 35 address scoring the risk assessment) which relies on answering all PREA risk assessment inquires to properly determine a detainee's risk for sexual victimization or sexual aggression. In addition, the facility commented "refusal to answer a single question or multiple questions can result in the inmate/detainee being placed under enhanced observation until further evaluation can be conducted" which is acceptable to the Auditor. The facility provided documentation to confirm all Intake and Classification staff have received training on scoring the risk assessment and the proper housing of detainees who refuse to answer or provide false information to the PREA risk score during the intake process. The facility submitted a memo to Auditor which states, "There were no detainees who refused to answer questions asked during the intake screening during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (f) of the standard.

(g): An interview with Intake staff, indicated Sexual Violence/Risk Assessment Screening is not stored on the computer. All detainee intake documentation is placed into a folder to be submitted to the Classification staff for completion. This includes the Sexual Violence/Risk Assessment Screening. The folders are kept on the intake desk, until picked up by Classification staff, in full view of all intake staff; however, according to Intake staff the risk assessment is in the backend of the paperwork so as not to be viewed by others.

Does Not Meet (g): The facility is not in compliance with subsection (g) of this standard. The facility has not implemented appropriate controls to prevent the dissemination of sensitive information gathered through responses to the intake screening. The completed screening is placed into a folder for Classification staff to pick up at a later time. The folders are kept on the officer's desk allowing anyone in the intake area to access the detainee folder. To become compliant, the facility must implement appropriate controls to prevent those that do not need to know, access to the sensitive information gathered through responses to the intake screening.

Corrective Action Taken (g): The facility submitted a photograph (b) (7)(E) [redacted] that depicts the storage area and the desk officer's proximately to the information that confirms proper controls of the detainee's responses to the initial risk assessment to prevent those that do not need to know access to the sensitive information gathered through responses to the intake screening. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (g) of the standard.

§115. 42 - Use of assessment information

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

Notes:

(a): OCSO policy, Classification, states, "Information will be taken into consideration when classifying inmates and detainees. NYS Suicide Screening Form and Sexual Violence/Risk Assessment Screening Form will be utilized to elicit and record information on each inmate relating to the following: visible injury/injuries on the inmate; medical conditions requiring immediate treatment; mental or physical handicap(s); history of mental illness or treatment; Potential for self-injury or suicide; history of detention or incarceration, including but not limited to hostile relationships with other inmates; medication currently being taken, present appearance and behavior; evidence of intoxication by alcohol or drugs or a history of alcohol or substance abuse, criminal charges and convictions; Any other relevant information concerning the safety or welfare of the inmate; and transgender or intersex." OCSO policy, Classification, further states, "ICE Detainees will be assigned housing based on the ICE Classification criteria. Detainees are classified by ICE Officials as follows: low, medium low, medium high or high" and "after the initial screening and risk assessment is completed prior to determining each inmates' s primary housing assignment, the inmate shall be placed in a housing area designated for classification purposes. Placement in such housing area shall be temporary pending completion of the classification process, including the determination of appropriate housing, which shall be completed within five (5) business days of each inmate's admission to the facility." During an interview with Classification staff, the Auditor confirmed ICE detainees are housed based on the classification level assigned by ICE. The Classification staff further indicated they can override the classification if the detainee is at risk for suicide or they discover additional criminal convictions that had not previously considered by ICE; however, the results of the initial risk screening are not considered and would not change the detainee classification level assigned by ICE. Classification staff further indicated, detainees will participate in recreation with other detainees housed in the housing unit and that detainees at the facility do not participate in work, volunteer, or other programming. The Auditor reviewed 15 detainee files, none of the files contained documentation to confirm the facility utilized the information received from the risk assessment to determine housing or recreation.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. During an interview with Classification staff, the Auditor confirmed ICE detainees will participate in recreation with other detainees housed in the housing unit; however, they are housed based on the classification level assigned by ICE and not from information received from the risk assessment. Classification staff further indicated detainees do not participate in work, volunteer, or other programming. To become compliant, the facility must develop and implement a procedure to ensure that information received from the risk assessment is utilized when determining a detainees initial housing assignment and recreation. Once implemented, the facility must document training of all applicable staff on the new procedure. In addition, the facility must provide 10 detainee files to confirm information from the risk screening was utilized when initial housing and recreation was determined.

Corrective Action Taken (a): The facility submitted documentation that confirms all applicable staff have been trained on the requirement that information received from the risk assessment is utilized when determining a detainee's initial housing assignment, recreation and other activities, and volunteer programming. The facility submitted three trustee clearance forms that confirmed although the review does not specify information from the intake screening was taken into consideration when determining recreation and other activities and volunteer programming it does include a section entitled "Other informative information" which the Auditor accepts. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

(b)(c): OCSO policy, Classification, states, "Transgender and Intersex inmates will be classified, will be referred to medical, mental health, and the PREA coordinator for review prior to making housing or program assignments." A review of OCSO policy, Classification, confirms it does not contain the requirement that placement and programming assignments of transgender and intersex detainees will be reassessed at least twice each year to review any threats to safety experienced by the detainee. The Auditor observed the shower areas in the facility. The Auditor reviewed a memo to the file, which states, "Be advised the Orange County Sheriff's Office has not taken any detainees that identify as transgender or intersex into custody during this audit cycle." During interviews with Intake staff, Classification staff and the HSA, the Auditor confirmed medical and mental health staff would be involved in housing a detainee who identifies as transgender/intersex, to ensure his/her health and safety. If the facility were to receive a detainee who identifies as transgender or Intersex, he or she would be housed in a medical cell, until medical staff and mental health personnel could determine the best course of action, that is consistent with the safety and security of the facility and the detainee completes initial classification. Interviews with Intake staff, Classification staff and the HSA could not confirm that placement and programming assignments would be reassessed at least twice each year to review any threats to safety experienced by the detainee. The Auditor observed the shower areas in the facility. All showers are individual showers with individual doors, allowing transgender or intersex detainees an opportunity to shower separately from other detainees. The facility reported there has

not been a transgender or intersex detainee, housed at the facility, during the audit period, therefore, the Auditor could not confirm, through a file review that a reassessment is conducted at least twice a year.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. In interviews with Classification staff the Auditor could not confirm that placement and programming assignments of a transgender or intersex detainee would be reassessed at least twice each year to review any threats to safety experienced by the detainee. To become compliant the facility must implement a practice that requires all transgender and intersex detainees' placement and programming assignments be reassessed at least twice each year to review any threats to safety experienced by the detainee. Once implemented the facility must train all classification staff on the updated practice and submit documentation of said training. If applicable, the facility must provide the Auditor with any transgender or intersex detainees who are eligible to be reassessed during the CAP period.

Corrective Action Taken (b): The facility submitted OCSO policy, Classification, which states, "All active files will be re-classified every 90 days…" and "the classification Officer will review the inmates' file. The Officer will check for any to the following a) change in legal status, b) adding or removal of holds, and c) violations of facility rules." A review of the policy confirms it does not require the classification officer to reassess the placement and programming of a detainee who identifies as transgender or intersex to review any threats to safety experienced by the detainee; however, the Auditor has accepted the re-classification of all detainees as compliant; and therefore, the facility is no longer required to implement a practice that requires all transgender and intersex detainees' placement and programming assignments be reassessed at least twice each year to review any threats to safety experienced by the detainee, train all classification staff on the updated practice, or provide the Auditor with any transgender or intersex detainees who are eligible to be reassessed during the CAP period. As the Auditor has accepted the re-classification of all detainees as compliant the facility is now in compliance with subsection (b) of the standard.

§115. 43 - Protective custody

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

Notes:

(a)(b)(c)(d)(e): OCSO policy, Protective Custody, Administrative Segregation, states, "Those inmates/detainees that are at a high risk for sexual victimization can only be placed in involuntary segregation if there is no available alternative means of separation from likely abusers. If an assessment for this segregation cannot be done immediately, it must be done in less than 24 hrs. When an inmate/detainee is placed in Involuntary Protective Custody, the Shift Commander will send a report to the Administrator and Captains identifying the inmate/detainee and detailing the reason for the placement. The Administrator will forward copies of the report to the Disciplinary Sergeant who will interview the inmate/detainee and to Classifications. On a weekly basis the Disciplinary Sergeant will review IPC cases. The Disciplinary Wing Sergeant will review all inmates/detainees in Segregation. Sergeants will interview the inmates/detainees and forward review sheets with recommendations to the Security Captain regarding the continuation of protective custody. Review forms will be signed off each week by the Corrections Administrator and the Security or On-Call Captain." OCSO policy, Protective Custody, Administrative Segregation, further states, "Protective Custody inmates/detainees are permitted the same rights as General Population inmates/detainees, with limitations in certain cases. Any limitation will be based on factors specific to the inmate's/detainee's situation, which would place him or her in danger if not restricted." A review of OCSO policy, Protective Custody, Administrative Segregation, confirms it does not require the facility not exceed a period of 30 days when placing a vulnerable detainee in administrative segregation for protective custody. In addition, OCSO policy, Protective Custody, Administrative Segregation, does not require a supervisory staff member conduct a 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, or the requirement to 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 on the basis of a vulnerability to sexual abuse or assault. The Auditor reviewed the Orange County Jail Protective Custody Initial Intake/Weekly Review form. The form indicates who requested protective custody, reason for protective custody, interview finds, and recommendations. During the on-site audit, there were no ICE detainees housed in protective custody. During an interview with the FA, the Auditor confirmed that New York State law prohibits facilities from having an administrative segregation unit in all detention facilities, to include the county jails and the corrections department. If protective custody is needed the detainee is confined to his/her cell to keep the detainee away from other detainees and is afforded at least seven hours outside their cell. If an ICE detainee is placed into protective custody, the ICE Field Office is notified immediately. The detainee has access to programs, visitation, counsel, and other services that are available to the general population. In addition, the Auditor confirmed in an interview with Agency PREA Coordinator, OCSO policy, Protective Custody, Administrative Segregation, has been reviewed and approved by the Agency.

Does Not Meet (b)(d)(e): The facility is not in compliance with subsections (b), (d), and (e) of the standard. A review of OCSO policy, Protective Custody, Administrative Segregation, confirms it does not require the facility not exceed a period of

30 days when placing a vulnerable detainee in administrative segregation for protective custody. In addition, OCSO policy, Protective Custody, Administrative Segregation, does not require a supervisory staff member conduct a 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, or the requirement to 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 on the basis of a vulnerability to sexual abuse or assault. To become compliant the facility must update OCSO policy, Protective Custody, Administrative Segregation to include all elements of the standard. In addition, the facility must refer the updated policy to the Agency for review and approval and submit documented training on all applicable staff on the updated policy. If applicable, the facility must submit to the Auditor any detainee files that include a detainee placed in administrative segregation (protective custody) as a result of being vulnerable to sexual abuse or assault.

Corrective Action Taken (b)(d)(e): The facility submitted OCSO policy, Protective Custody/Administrative Segregation, which confirms any detainee who requires Protective Custody due to being vulnerable to sexual abuse will immediately be removed from the facility by ICE. The facility submitted documentation to confirm all applicable staff have been trained on the updated policy. The facility submitted a memo from the AFOD which confirms policy Protective Custody/Administrative Segregation was developed in conjunction with the Agency. In addition, the facility submitted a memo that states, "There were no detainees vulnerable to sexual abuse that arrived at Orange County Jail during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (b), (d), and (e) of the standard.

§115. 51 - Detainee reporting

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

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "Inmates/detainees shall be encouraged to promptly report signs or incidents of sexual abuse and assault and may not be punished for reporting. Staff shall take seriously all statements from inmates/detainees claiming to be victims of sexual assaults and shall respond supportively and non-judgmentally. Any inmate/detainee may report acts of sexual abuse or assault to any employee, contractor, or volunteer. If an inmate/detainee is not comfortable with making the report to immediate point-of-contact line staff, he/she shall be allowed to make the report to a staff person with whom he/she is comfortable speaking with about the allegations." A review of OCSO policy, SAAPI, confirms it does not contain verbiage that ensures detainees have multiple ways to privately report retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. During the on-site audit, the Auditor observed information on the detainee tablets that advised the detainee's how to contact their consular officials, ORCCC, and the DHS OIG to report an incident of sexual abuse confidentially and anonymously by utilizing the numbers provided. During the on-site audit, the Auditor tested the phone numbers provided, utilizing a detainee tablet and pin. The numbers were in good working order. The Auditor informally interviewed an advocate employed by OCRCC and confirmed the services which are provided to the detainees. In addition, the Auditor attempted to call the DHS OIG. The number rang and it hung up. Interviews with security line staff and supervisors, and the facility PREA Compliance Manager, confirmed detainees at OCCF are provided multiple ways to report sexual abuse, which include telling a staff member, filing a grievance, or reporting to OCRCC.,

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The facility provides the detainees multiple ways to report sexual abuse; however, a review of OCCF's policy, SAAPI, DHS OIG posters, the facility handbook, and the Intake Orientation form, could not confirm that the facility informs the detainee they can report retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. The Auditor tested the OCRCC number provided on the detainee tablets and confirmed, although the agency would provide a way for the detainee to report an incident of sexual abuse confidentially, the detainee would need to use a pin number to complete the call; and therefore, the call would not be anonymous. The Auditor tested the DHS OIG number provided to the detainees; and confirmed although the line rang it immediately hung up. To become compliant the facility shall develop and implement multiple ways for detainees to anonymously report sexual abuse, retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. Once implemented, information on how to anonymously report an incident of sexual abuse, retaliation for reporting sexual abuse and staff neglect or violations that may have contributed to such incidents shall be disseminated to the ICE detainee population in a manner that all detainees can understand, and documentation of such, shall be forwarded to the Auditor.

Corrective Action Taken (a): The facility submitted a brochure for the Rape Crisis Center that confirms it allows for a speed dial to report sexual abuse. The facility submitted The ICE National Detainee Handbook, page 21, which includes the verbiage "If you experience retaliation for reporting sexual abuse or assault, participating in an investigation about sexual abuse or assault, or for engaging in sexual activity as a result of force or coercion, you can report it in the same way that

you report an incident of sexual abuse or assault." In addition, a review of the ICE National Detainee Handbook confirms the handbook provides instruction on how to report staff misconduct on page 18, which the Auditor accepts for the requirement that includes staff neglect or violations that may have contributed to such incidents. The facility provided the Auditor 3 photographs of detainee tablets which confirmed the facility has uploaded the 2021 ICE National Detainee Handbooks which include the 14 most prevalent languages encountered by ICE onto the detainee tablets. Upon review of all available information the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 53 - Detainee access to outside confidential support services

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

Notes:

(a)(b)(c)(d): A review of OCSO policy, SAAPI, confirms it includes outside agencies including MHA, OCRCC, and the NYS Hotline for Sexual Assault and Domestic Violence with contact numbers in their SAAPI protocol. The Auditor reviewed an MOU between MHA, OCRCC, and the OCCF. The MOU lays out the responsibilities of OCRCC, established under the umbrella of MHA, which include providing phone advocacy, responding to calls made by hospital personnel for incarcerated individuals who present in the hospital, provide emotional support and referral information during an investigation, and conduct trainings for law enforcement in regard to sexual assault services. During the on-site audit, the Auditor observed a flyer, in English and Spanish, on the detainee tablets that includes information about OCRCC, and the services provided. The flyer informs detainees that all services are confidential. The Auditor tested the phone numbers provided, utilizing a detainee tablet and pin. The numbers were in good working order. The Auditor informally interviewed an advocate employed by OCRCC and confirmed the services which are provided to the detainees. The Auditor reviewed the facility handbook and confirmed it advises detainees that phone calls are subject to monitoring. In addition, the Auditor reviewed the Orientation Document that indicated "Information concerning the identity of an inmate-victim reporting a sexual assault or abuse, and the facts of the report itself, shall be limited to those involved in the reporting, investigation, discipline, and treatment process, or as otherwise required by law; however, both pieces of information were not accessible to all detainees in their preferred language. Informal interviews with detainees, indicated they were not aware of the OCRCC, or the services provided, and could not articulate if the calls were confidential, monitored or recorded.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The Auditor reviewed the facility handbook and confirmed that it contains the verbiage, "All phone calls are recorded and may be monitored." In addition, the Auditor reviewed the facility handbook and confirmed it advises detainees that phone calls are subject to monitoring. In addition, the Auditor reviewed the Orientation Document that indicated "Information concerning the identity of an inmate-victim reporting a sexual assault or abuse, and the facts of the report itself, shall be limited to those involved in the reporting, investigation, discipline, and treatment process, or as otherwise required by law; however, both pieces of information were not accessible to all detainees in their preferred language. Informal interviews with detainees, indicated they were not aware of the OCRCC, or the services provided, and could not articulate if the calls were confidential, monitored or recorded. To become compliant the facility must provide detainees with the extent to which reports of abuse will be monitored and forwarded to authorities in accordance with mandatory reporting laws in a manner that all detainees will understand. In addition, the facility must provide the Auditor with documentation that confirms the detainees were provided the information in a manner that all detainees can understand.

Corrective Action Taken (d): The facility submitted a copy of the inmate handbook that confirms it advises detainees that all phone calls will be monitored. The facility submitted a photo of a housing unit posting in English and Spanish that confirms it advises detainees the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Upon review of all available documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

§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): Agency Policy 11062.2, states, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." OCSO policy, SAAPI, states, "Staff shall accept any report made verbally, in writing, anonymously and from third parties. 2) All staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault to the Shift Commander. The Shift Commander shall assure all reports are kept private and only disseminated to on a need-to-know basis to authorized first responders. 3) Staff shall promptly document any allegations reported to them in the form of a report. 4) All cases that appear potentially to support criminal prosecution shall be referred to the Orange County Sheriff's Office Investigations Unit.

5) If the incident involves an ICE detainee, the ICE SAAPI Assessment form will be completed and the Corrections Administrator or designee shall immediately report the incident to the ICE Field Office Director, 6) If an employee, contractor, or volunteer is alleged to be the perpetrator of inmate/detainee sexual abuse or assault, the Corrections Administrator shall also notify the local government entity or contractor that operates the facility. 7) Information concerning the identity of an inmates'/detainees' victim reporting a sexual assault, and the facts of the report itself, shall be limited to those who have a need-to-know in order to make decisions concerning the victim's welfare, and for law enforcement/investigative purposes." A review of OCSO policy, SAAPI, confirms it does not include a method by which staff can report outside the chain of command. The Auditor reviewed the facility staff PREA training curriculum, which states, "Staff will immediately report any allegation received to their supervisor (unless complaint is about their supervisor) or the Shift Commander." Interviews with security line staff and supervisors, indicated staff are aware of the requirement to immediate report a sexual abuse incident and they could report an allegation outside of their chain of command, if necessary. Staff were also aware; that information regarding an incident of sexual abuse is limited to those that need-to-know, to keep the detainee safe, prevent further victimization or to make medical treatment, investigation, law enforcement or other security and management decisions. Security line staff and supervisors did not articulate the need to report any knowledge, suspicion, or information regarding a sexual abuse, the need to report retaliation against a detainee or staff who reported or participated in an investigation about such an incident, or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. During an interview with the PSA Compliance Manager, the Auditor confirmed OCSO policy, SAAPI, was submitted to the Agency for review and approval.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of OCSO policy, SAAPI, confirmed it does not include a method by which staff can report outside the chain of command. In addition, security line staff and supervisors did not articulate the need to report any knowledge, suspicion, or information regarding a sexual abuse, the need to report retaliation against a detainee or staff who reported or participated in an investigator about such an incident, or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. To become compliant, the facility must update OCCF's policy, SAAPI, to include a method by which staff can report outside the chain of command. Once updated, the facility must refer the updated policy to the Agency for review and approval. In addition, the facility must train all staff on the requirement to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred at the facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation and document said training.

Corrective Action Taken (a): The facility submitted documentation that confirms updated OCCF policy, SAAPI, includes a method by which staff can report outside the chain of command. The facility submitted documentation to confirm all staff have been trained on the standard's requirement to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred at the facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 63 - Reporting to other confinement facilities

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

Notes:

(a)(b)(c)(d): OCSO policy, SAAPI, states, "Upon receiving an allegation that an inmate/detainee was sexually abused while confined at another facility, the Corrections Administrator shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The Corrections Administrator shall notify the inmates/detainees in advance of such reporting." An interview with the FA confirmed the facility would immediately notify the facility Warden at the facility where the abuse occurred. The notification would initially be made through a phone call and would be followed up with an email. In addition, he would notify the ICE Field Office of the report. The facility Administrator was aware the notification must be made within 72 hours; however, he confirmed he would not wait that long and would immediately notify the facility. If OCCF received such a notification, it would be immediately referred for investigation and notification made to the ICE FOD. The facility provided the Auditor a memorandum regarding an ICE detainee who reported an allegation of sexual abuse that occurred at another facility. The memo is address to the Sheriff of Orange County from a facility investigator. Although the facility notified the ICE FOD, no documentation was provided to indicate that the facility had notified the facility where the incident occurred that they had received an allegation of sexual abuse from their facility.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsection (a) of this standard. The facility provided the Auditor a memorandum regarding an ICE detainee who reported an allegation of sexual abuse that occurred at another

facility. The memo is address to the Sheriff of Orange County. No documentation was provided to indicate that the facility, where the incident occurred was notified of the allegation; and therefore, there is no documentation to confirm the provided notification was made to the facility where the allegation took place or that they notification was documented. To become compliant, the facility shall develop and implement procedures to ensure that upon receiving an allegation that a detainee was sexually abused while confined in another facility, the facility shall notify the appropriate office of the agency or the administrator of the facility where the alleged abuse occurred, and forward documentation of such to the Auditor. Once developed the facility must train all applicable staff on the new procedure and submit documentation that confirms the require training was conducted. If applicable, the facility must submit to the Auditor any documents that include any detainees who reported to OCCF during the CAP period of being sexually abused while housed at another facility.

Corrective Action Taken (a)(b)(c): The facility submitted PREA Standard 115.63 Report of Sexual Abuse which confirmed the notification to Riker's Island was delivered at the time the allegation was made. Therefore, the Auditor waves the requirements the facility develop and implement procedures to ensure that upon receiving an allegation that a detainee was sexually abused while confined in another facility, the facility shall notify the appropriate office of the agency or the administrator of the facility where the alleged abuse occurred, and the facility must train all applicable staff on the new procedure. In addition, the Auditor waves the requirement the facility must submit to the Auditor any documents that include any detainees who reported to OCCF during the CAP period who reported an allegation of sexual abuse while housed at another facility. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

§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): OCSO policy, SAAPI, states, "Staff First Responder Duties: 1) Separate the alleged victim and abuser. 2) If staff is alleged to be the sexual abuser, they are to be removed from contact with inmates pending the outcome of the investigation. 3) Preserve and protect any crime scene until appropriate steps can be taken to collect evidence. 4) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take actions that could destroy physical evidence, including as appropriate, washing, washing clothes, brushing teeth, changing clothes, urinating, defecating, drinking, or eating. 5) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including as appropriate, washing, washing clothes, brushing teeth, changing clothes, urinating, defecating, drinking, eating." A review of OCCF's SAAPI confirms it does not include the responsibilities of a non-security first responder during an incident of sexual abuse. In interviews with Security line staff and supervisors, it was confirmed that all the interviewees were knowledgeable in their duties as a first responder, to include if a detainee reported an allegation of sexual abuse to them, they would call for backup, separate the detainee, call for medical, request the detainee victim and ensure the alleged abuser not to take any action that could destroy physical evidence, preserve the crime scene and notify the supervisor. In interviews with a nurse and a mental health provider, each reported they would call for backup, tell them to stop and separate them if they could and notify the supervisor; however, neither non-security first responder indicated that they would request the alleged victim not take any actions that could destroy physical evidence prior to notifying security staff. The Auditor reviewed two reported allegations of detainee-on-detainee of sexual abuse, both cases were reported days later, and therefore, did not include the actions of facility first responders.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. A review of OCSO policy, SAAPI, confirms it does not include the responsibilities of a non-security first responder during an incident of sexual abuse. In addition, neither non-security first responder interviewed, indicated that they would request the alleged victim not take any actions that could destroy physical evidence prior to notifying security staff. To become compliant the facility must update OCSO policy, SAAPI, to include the requirements of non-security first responders. Once updated the facility must refer updated OCSO policy, SAAPI, to the Agency for review and approval. In addition, the facility must train all staff, contractors, and volunteers who have reoccurring contact with detainees on the non-security first responder responsibilities, including requesting the victim not to take any actions that would destroy physical evidence prior to notifying security staff, and document said training.

Corrective Action Made (b): The facility submitted updated policy, SAAPI, that confirms it requires non-security first responders to request the detainee not to take any actions that could destroy physical evidence and notify security staff. The facility submitted non-security first responder training records that confirm non-security first responders have received training on their responsibilities as non-security first responders. Upon review of all submitted documentation the Auditor now find the facility in compliance with subsection (b) of the standard.

§115. 65 - Coordinated response

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

Notes:

(c)(d): A review of OCSO policy, SAAPI, confirmed the coordinated response plan does not include verbiage for subsections (c) and (d) of the standard, which requires if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "If the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise. During an interview with the FA, he could not articulate what information would be shared stating, "he believed ICE staff and medical staff would be responsible to inform the receiving facility of an incident and the need for medical and social services."

Does Not Meet (c)(d): The facility is not in compliance with subsection (c) and (d) of this standard. A review of OCCF's Coordinated Response Plan confirms it does not include the verbiage for subsections (c) and (d) which require a coordinated plan that includes, (c) if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and (d) if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise. In addition, an interview with the FA could not confirm compliance with subsections (c) and (d). To become compliant, the facility shall revise and update OCCF's Coordinated Response Plan to include the verbiage required by subsections (c) and (d) of the standard. Once updated the facility must provide a copy of OCCF's Coordinated Response Plan to the Auditor to confirm its compliance with subsections (c) and (d0 of the standard. In addition, the facility must train all staff included in the Coordinated Response Plan on the requirements of subsections (c) and (d) of the standard. If applicable, the facility must provide the Auditor with any sexual abuse investigation files, and corresponding medical and mental health records, of a detainee who was transferred due to an incident of sexual abuse to confirm compliance with the standard.

Corrective Action Made (c)(d): The facility submitted updated OCCF's Coordinated Response Plan which states, "Transfer of Records - 2. ICE Detainees are transferred by ICE and the facility will provide all records requested by ICE in accordance with established ICE procedures. As the plan advises staff ICE will make the decision as to what records to transfer and ICE provided their policy for transfer of records, which the Auditor found compliant, the Auditor accepts facility staff have clear direction on the procedure to transfer detainee records in accordance with subsections (c) and (d) of the standard. In addition, the facility submitted a memo to the Auditor that confirms there have been no allegations of sexual abuse reported at Orange County Jail during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (c) and (d) of the standard.

§115. 67 - Agency protection against retaliation

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

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "For at least 90 days following a report of sexual abuse, this agency shall monitor the conduct and treatment of inmates or staff who reported the sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by inmates or staff and shall act promptly to remedy any such retaliation. SRG/CIU member designated to monitor for retaliation shall review inmate disciplinary reports, inmate housing assignments and program changes. For staff, negative performance reviews and post assignments will be monitored. The assigned SRG/CIU member will conduct bi-weekly reviews and document all reviews on the retaliation monitoring form. The retaliation monitoring form will be forwarded to the PREA Coordinator upon completion." In an interview with the RM, the Auditor confirmed detainees who report an allegation of sexual abuse or cooperate with an investigation are monitored for 90 days following the report and that monitoring will continue beyond 90 days if needed; however, the RM could not articulate the need to monitor staff and review post assignments, negative reviews, or reassignments. The Auditor reviewed the facility PREA Retaliation Monitoring Form, which indicates a review of the detainee's disciplinary records, housing, mental health issues, medical issues, and programming. The facility RM

reported he will meet with the detainee every two weeks, to ensure there is no retaliation. In addition, he confirmed that there had not been a staff member that required retaliation monitoring during the audit period. The Auditor reviewed two investigations, and confirmed monitoring occurred for the required 90 days in one file. The second file did not contain documentation of retaliation monitoring, as it was determined to be unfounded. There were no detainees who reported an incident of sexual abuse housed at the facility, therefore no interviews were completed.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of this standard. The Auditor reviewed two investigations. Retaliation monitoring could be seen in one of the investigative files; however, monitoring documentation could not be confirmed in the investigation the facility determined to be unfounded. In addition, during an interview with the facility investigator, he could not articulate the need for monitoring a staff member that may report or witness and allegation. To become compliant, the facility shall implement a procedure, to ensure that all detainees and staff who report, witness, or cooperate with an investigation are monitored for up to 90 days or longer if needed. In addition, the facility must train all applicable staff on the new procedure. Once the training is completed, the facility must provide the Auditor with documentation that confirms if was conducted. If applicable, the facility must submit to the Auditor all allegation of sexual abuse investigation files, and the corresponding PREA Retaliation Monitoring form, that occurred during the CAP period.

Corrective Action Taken (a)(b)(c): The facility submitted updated OCSO policy, SAAPI, that confirms it ensures all detainees and staff who report, witness, or cooperate with an investigation are monitored for up to 90 days or longer if needed. The facility submitted an email to all applicable staff that confirm all staff involved in retaliation monitoring have been trained on the standards requirements. The facility submitted a read receipt to confirm the information was disseminated. In addition, the facility submitted a memo to the Auditor that confirms there have been no allegations of sexual abuse reported at Orange County Jail during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), and (c) of the standard.

§115. 71 - Criminal and administrative investigations

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

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "A prompt, thorough, objective, and fair investigation shall be conducted into all allegations, including third party and anonymous reports of sexual abuse or assault" and "investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses, and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect or witness shall be assessed on an individual basis and shall not be determined by the person's status as inmate or staff. An inmate that alleges sexual abuse shall not be subjected to a polygraph examination or other truth telling device as a condition for proceeding with the investigation. Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attached copies of all documentary evidence where feasible. Substantiated allegations of conduct that appear to be criminal shall be referred for prosecution. All Administrative investigations shall include an effort to determine whether staff actions or failure to act contributed to the abuse. For all Administrative investigations, this agency shall not impose any standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. All Administrative investigations shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings. The ICE SAAPI Assessment form will be attached to all facility documents." OCCF's policy, SAAPI, further states, "In addition, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling, shall, be maintained in the PREA file." A review of OCSO policy, SAAPI, confirms it does not contain verbiage that requires the facility to retain reports of sexual abuse for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. An interview with a facility Investigator confirmed the facility will conduct an administrative investigation on all allegations of sexual abuse. The investigator will work with the criminal investigators, to ensure that the criminal case is not compromised. In addition, the facility Investigator, the facility PSA Compliance Manager, and the facility Administrator confirmed investigations are prompt, thorough and objective. In an interview with the PSA Compliance Manager, it was indicated that he would notify the ICE FOD if a detainee victim has been held in administrative segregation for 72 hours. The Auditor reviewed two investigations and determined the allegations did not rise to the level that would require a criminal investigation and that all requirements of subsection (c) had been followed.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of OCSO policy, SAAPI, confirms it does not contain verbiage that requires the facility to retain reports of sexual abuse for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. To become compliant the facility must update OCSO policy, SAAPI, to include the verbiage "The facility to retain reports of sexual abuse for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." In addition, the facility must document that all facility Investigators have been trained on updated OCSO policy, SAAPI, and that the updated policy was submitted to the Agency for review and approval.

Corrective Action Taken (c): The facility provided updated OCSO policy, SAAPI, which confirms it requires the facility to retain reports of sexual abuse for as long as the alleged abuser is detained or employed by the agency or facility, plus 15/7 years. The facility submitted documentation that confirms all facility Investigators have been trained on updated OCSO policy, SAAPI. The facility submitted documentation that confirms updated OCSO policy, SAAPI, was submitted to the Agency for review and approval. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

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

Outcome: Does not Meet Standard

Notes:

(a)(b)(c): OCSO policy, Health Services, states, "Inmates/Detainees who have been victims of sexual abuse in any prison, jail, lock up or juvenile facility, are referred urgently to Mental Health for evaluation within 72-hours; if mental health is not available, the inmate is placed in isolation until evaluated." OCSO policy, Health Services, further states, "The Mental Health staff will evaluate any inmate/detainee referred as a sexual assault risk (potential victim or predator). If Mental Health staff determine through their screening process that an inmate/detainee is a sexual assault risk (potential victim or predator, the following actions will be taken: mark the sexual assault risk box in the Offender Management System; inform Classification staff; and schedule a follow-up visit for the inmate/detainee within 14 days (only if inmate/detainee was not determined a risk by any other department). Inmates/Detainees who have been victims of sexual abuse in any prison, jail, lock-up or juvenile facility shall be evaluated and receive appropriate treatment." During an interview with Intake staff, the Auditor confirmed that each detainee is assessed by Intake staff utilizing the facility Sexual Violence/Risk Assessment Screening form. If the detainee score is 4 or higher, the detainee is referred to mental health. Affirmative answers to questions, that require an automatic referral to mental health are scored as a 5, to ensure a referral is completed. Interviews with Intake staff and Classification staff confirmed the scoring process on the assessment and when a referral to medical and mental health is necessary. Interviews with medical staff and mental health staff confirmed the process. In addition, the Auditor confirmed medical staff will complete their own assessment of the detainees during the intake process, if a referral is needed, medical staff will immediately follow up with the detainee or immediately complete a referral for a mental health follow-up. Medical staff indicated that there have been no referrals for medical or mental health, as a result of the risk assessment, during the reporting period. The Auditor reviewed 15 detainee files. No detainees required a medical referral for a medical follow up. There were no detainees who scored high for victimization, however; two detainees scored high for risk of predatory behavior. The files did not contain documentation that a referral had been completed. The Auditor reviewed the mental health file of both detainees. One file indicated that there was a referral completed at intake, the other file did not. The detainee file that had documentation of the referral, came into the facility on October 13, 2021, referral was picked up by mental health staff on October 14, 2021, the detainee was seen on October 26, 2021. The second detainee came into the facility on October 21, 2021, no referral was documented; however, the detainee was seen by mental health staff on and OCCF's October 28, 2021.

Does Not Meet (a)(c): The facility is not in compliance with subsections (a) and (c) of this standard. The Auditor reviewed 15 detainee files and confirmed there were no detainees who scored high for victimization; however, two detainees scored high for risk of predatory behavior. A review of the detainee files did not contain documentation that a referral had been completed; however, the Auditor reviewed the corresponding mental health file of both detainees and confirmed one file indicated that there was a referral completed at intake, the other file did not. The detainee file that had documentation of the referral, came into the facility on October 13, 2021, referral was picked up by mental health staff on October 14, 2021, and the detainee was seen on October 26, 2021. The second detainee came into the facility on October 21, 2021, no referral was documented; however, the detainee was seen by mental health staff but not until October 28, 2021. The Auditor confirmed both detainees who scored high for risk of predatory predator were not seen within the required 72 hours. To become compliant, the facility must ensure that the detainee is referred to a qualified medical or mental health professional if the Sexual Violence/Risk Assessment Screening form indicates a detainee has experienced sexual abuse or perpetrated sexual abuse. In addition, the facility must implement a practice that requires the detainee is seen no later than 72 hours after a referral for a mental health follow-up due to the detainee experiencing prior victimization or perpetrating sexual abuse. The facility must train all intake, medical and mental health staff in the new practice and document such training. In addition, if applicable, the facility shall forward 10 detainee files that include detainees who scored high for victimization or predatory behaviors.

Corrective Action Taken (a)(c): The facility submitted the facility Mental Health Services policy which states, "Mental health staff will review requests within three (3) business days and provide services as appropriate; however, the standard requires detainees who have experienced prior sexual abuse victimization or perpetrated sexual abuse and are referred to Mental Health will be provided a mental health evaluation within 72 hours of the initial referral. The facility submitted booking referrals for mental health for two detainees who received an elevated PREA score; however, the Auditor requested the files of two specific detainees who were identified as being sexual predators which were not provided. In addition, although requested throughout the CAP period, the facility did not submit mental health records to determine if the mental health contact was the result of an intake referral due to the detainee being identified to have experienced prior sexual abuse victimization or perpetrated sexual abuse. Upon review of all submitted documentation, and the lack thereof, the Auditor continues to find the facility does not meet subsections (a) and (c) of the standard.

§115. 86 - Sexual abuse incident reviews

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

Notes:

(c): OCSO policy, SAAPI, states, "The PREA Coordinator shall review aggregate data on an annual basis and present the findings to the ICE Field Office Director and ICE/ERO headquarters for use in determining whether changes may be needed to existing policies and practices in order to further the goal of eliminating sexual abuse." The Auditor reviewed the OCCF's PREA Coordinator's Annual report for 2020; however, the facility did not provide an annual report for 2022. The 2020 report was addressed to the Orange County Sheriff's Office. An interview with the PSA Compliance Manager indicated the report, or negative report if no allegations of sexual abuse were reported for the year, is forwarded to the Sheriff. The Auditor did not receive documentation that the annual report is forwarded to the FOD or the Agency PSA Coordinator.

Does Not Meet (c): The facility is not in compliance with subsection (c) of this standard. The Auditor reviewed the OCCF's PREA Compliance Manager's Annual report for 2020; however, the facility did not provide a report for 2022. The 2020 report is addressed to the Orange County Sheriff's Office. An interview with the PSA Compliance Manager indicated the report, or negative report if no sexual abuse allegations were reported for the year, is forwarded to the Sheriff. In addition, the Auditor did not receive documentation that the annual report is forwarded to the FOD or the Agency PSA Coordinator. To become compliant, the facility must provide the Auditor documentation that the 2022 annual PREA report, or negative report, has been completed and forwarded to the FOD, or his or her designee, and the Agency PSA Coordinator.

Corrective Action Taken (c): The facility submitted the annual report for 2022. The facility submitted an email that confirms the 2022 annual report was submitted to ICE ERO FOD and the Agency PSA Coordinator. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

AUDITOR CERTIFICATION:

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

Robin Bruck October 5, 2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) October 16, 2023

Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) October 16, 2023

Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	1/10/2023	**To:**	1/12/2023
AUDITOR INFORMATION			
Name of auditor:	Robin M. Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	New York Field Office
Field Office Director:	Kenneth Genalo
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	26 Federal Plaza, New York, NY 10924
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:	Orange County Jail		
Physical address:	110 Wells Farm Road, Goshen, NY 10924		
Mailing address: (if different from above)			
Telephone number:	845-291-4033		
Facility type:	IGSA		
PREA Incorporation Date:	2/21/2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Captain
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	845-291-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Captain
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	845-291-(b) (6), (b)

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of Orange County Jail (OCJ) and also referred to as the Orange County Correctional Facility (OCCF) was conducted January 10-12, 2023, by U.S. Department of Justice and DHS Certified PREA Auditor, Robin M. Bruck, employed by Creative Corrections, LLC. The Auditor was provided guidance during the audit report writing and review process by US Immigration and Customs Enforcement (ICE) PREA Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight for the ICE PREA audit process and liaison with ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility's compliance with the DHS PREA Standards. OCCF is a county government facility governed by the Orange County Sheriff's Office (OCSO) and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). This audit was the first DHS PREA audit for this facility and included a review of the period between February 21, 2020, through January 12, 2023.

Approximately four weeks prior to the audit, ERAU Team Lead (TL) (b) (6), (b) (7)(C) provided the Auditor with the facility's PREA-Audit Questionnaire (PAQ), Agency policies, and other documents. All documentation was provided to the Auditor through the ICE SharePoint. The PAQ and supporting documentation were organized with the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into folders for ease of auditing. The main policy that governs OCCF's PREA Program is the OCSO's Sexual Abuse and Assault Prevention, and Intervention Program (SAAPI). All the documentation, policies, and the PAQ were reviewed by the Auditor.

The entry briefing was held in OCCF's conference room at 8:00 a.m. on Tuesday, January 10, 2023. The ICE ERAU TL opened the briefing via telephone and turned it over to the Auditor. In attendance via telephone were:

(b) (6), (b) (7)(C) ICE/OPR/ERAU Inspections and Compliance Specialist (ICS)
(b) (6), (b) (7)(C) Deputy Field Office Director (DFOD)

In attendance at the facility were:

(b) (6), (b) (7)(C) OCSO Captain
(b) (6), (b) (7)(C) OCSO Captain, Prevention of Sexual Assault (PSA) Compliance Manager
(b) (6), (b) (7)(C) OSSO Sergeant
(b) (6), (b) (7)(C) OCSO Compliance Sergeant
(b) (6), (b) (7)(C) ICE/ERO Supervisory Detention and Deportation Officer (SDDO)
(b) (6), (b) (7)(C) OCSO Fire Safety Officer (FSO)
(b) (6), (b) (7)(C) OCSO Officer
Robin Bruck, PREA Auditor, Creative Corrections, LLC

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

An on-site tour was conducted by the Auditor with key staff from OCCF and ICE. All housing units were toured, as well as program areas, control centers, booking/intake, recreation areas, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or provided services, were observed by the Auditor. During the tour, the Auditor made visual observations of the housing units including bathrooms and shower areas, officer post sight lines and camera locations. Sight lines were closely examined, as was the potential for blind spots, throughout areas where detainees are housed or have access. In addition, the Auditor spoke to random staff and detainees regarding PREA education and the facility practices during the on-site tour. A review of the housing unit logbooks was conducted to verify rounds were being conducted by both custody line and supervisory staff. The physical plant consists of one building with an administrative area and 19 housing units comprised of 16 single cell units and 3 dorms. The facility has a design capacity of 802. The current population on the first day of the audit was 299 which consisted of 74 male ICE detainees and 3 female ICE detainees. The remaining population consists of inmates who do not comingle with detainees. Male ICE detainees are housed within two single cell housing units. The female detainees occupy a housing unit which is divided and includes both a dorm area and an area that consists of single cells. The dorm portion of the unit is not in use. According to facility staff, each ICE

detainee housed at the facility is being held on current criminal charges that are being processed through the court system and have an immigration hold. Within each housing unit there are (b) (7)(E) a telephone, a television, and showers. During the on-site tour, the Auditor observed that PREA Information was not posted on the housing unit bulletin boards. Detainees are provided with a facility tablet at no cost. The tablet contains the facility policies, the facility handbook, the ICE Detainee Handbook, as well as other information. With the exception of the facility handbook which is accessible in English, Spanish, and French all PREA information was accessible in English and Spanish only. Detainees utilize the tablets to make phone calls and to participate in video visits. The showers in the male housing units were covered by a half door that allowed the detainee to shower in private, with only their heads and feet in view. Showers in the female units were fully covered by a shower curtain. The facility did not have group shower areas. Toilets were seen in the individual cells and were positioned to the side of the door's window eliminating any issues with cross-gender viewing.

The facility PAQ reported 334 OCCF staff and 5 ICE staff who may have recurring contact with detainees, which includes 283 security staff (229 males and 54 females), 25 medical staff, 7 mental health staff, and 19 administrative staff. The facility provided the requested information to be used for selection of the detainee and staff interviews. The Detainee roster was provided in alpha order and contained the housing unit for all detainees housed at the facility. In addition, the facility provided a staff roster that included duty positions and shifts. There were zero volunteers at the facility for the Auditor to interview during the on-site audit. The Auditor formally interviewed 20 ICE detainees, which included 18 male and 2 female detainees. Seven detainees were limited English proficient (LEP) and required the use of a language interpreter through Language Service Associates, provided by Creative Corrections, LLC, and four detainees had completed the intake process the night before. Each interview was conducted in the barber shop, which provided confidentiality for those participating in the interviews. The Auditor formally interviewed a total of 23 OCCF staff, 5 contractor staff and 1 ICE staff. Each interview was conducted in the OCCF conference room, which provided confidentiality for those participating in the interview. The OCCF staff interviews included the Facility Administrator (FA), the PSA Compliance Manager, the Volunteer Coordinator, facility Investigator (1), the Grievance officer (GO), disciplinary officer, Human Resource staff (HR), Classification staff (1), Intake staff (1), non-custody first responders (3), custody first responders (2), the Retaliation Monitor (RM), and Security line staff (5) and supervisors (2). Contract staff interviewed included WellPath medical staff (3), which included 1 nurse practitioner, and two Licensed Practical Nurses (LPN), the Mental Health Director, and a Trinity Food Service cook. ICE staff interviewed included one SDDO.

The facility uses 12 trained investigators to complete all allegations of sexual abuse. There were two sexual abuse allegations reported during the audit period. A review of the PREA allegation spreadsheet indicated that both cases were closed and involved a detainee-on-detainee. Of the two cases reported, one was determined to be unfounded, and one was determined to be unsubstantiated. The ICE OPR and JIC were notified of both allegations as documented in the investigation files and on the PREA allegation spreadsheet. There were no cases referred for prosecution.

An exit briefing was conducted on Thursday, January 12, 2023, at 2:00 p.m. in the OCCF conference room. The ICE ERAU TL opened the briefing via telephone and turned it over to the Auditor. In attendance via teleconference were:

(b) (6), (b) (7)(C) ICE/OPR/ERAU/ICS
(b) (6), (b) (7)(C) DFOD
(b) (6), (b) (7)(C) PM, Creative Corrections, LLC

In attendance at the facility were:

(b) (6), (b) (7)(C) OCSO Undersheriff
(b) (6), (b) (7)(C) OCSO Captain
(b) (6), (b) (7)(C) OCSO Captain, PSA Compliance Manager
(b) (6), (b) (7)(C) OCSO Compliance Sergeant
(b) (6), (b) (7)(C) ICE/ERO SDDO
(b) (6), (b) (7)(C) ICE/ERO Detention Services Manager (DSM)
(b) (6), (b) (7)(C) OCSO FSO
(b) (6), (b) (7)(C) OCSO Officer
Robin Bruck, PREA Auditor, Creative Corrections, LLC

The Auditor spoke briefly about the staff knowledge of the OCCF PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit and that she would need to review all submitted documentation, interview notes, and on-site observations. She thanked all present for their cooperation. The TL explained the audit report process and timeframes.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

Number of Standards Not Applicable: 2

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

Number of Standards Met: 17

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.21 Evidence protocols and forensic medical examinations
§115.34 Specialized training: Investigations
§115.52 Grievances
§115.54 Third-party reporting
§115.62 Protection duties
§115.66 Protection of detainees from contact with alleged abusers
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.83 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: 22

§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.35 Specialized training: Medical and Mental Health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.53 Detainee access to outside confidential support services
§115.61 Staff reporting duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.71 Criminal and administrative investigations
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

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

Notes:

(c): The facility follows OCSO's written policy and procedure, SAAPI, mandating zero-tolerance towards all forms of sexual abuse and sexual harassment. OCSO policy, SAAPI, includes definitions of sexual abuse and general PREA definitions. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, in both English and Spanish, posted in the intake area only. Formal and informal interviews with facility staff confirmed their knowledge of the zero-tolerance of sexual abuse within the facility. Interviews with the Agency PSA Coordinator/SDDO and the facility PSA Compliance Manager confirmed that the facility has submitted OCSO policy, SAAPI, to the Agency for review and has received approval.

(d): OCCF has designated a Captain to serve as the facility PSA Compliance Manager. An interview with the PSA Compliance Manager, confirmed that he has sufficient time and authority to oversee the facility's efforts to comply with the facility sexual abuse prevention and intervention policies and procedures. In addition, the PSA Compliance Manager reported he serves as the facility point of contact for the Agency PREA Coordinator.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): A review of the facility PAQ indicated OCCF has a total of 334 staff that have recurring contact with detainees, which includes 283 security staff, (229 males and 54 females) and 25 medical staff and 7 mental health staff, which are contracted through Well Path. The remaining staff consists of support personnel in administration and contracted food service staff through Trinity Food Services. In addition, the facility has five full-time ICE staff employed at the facility. According to the PAQ, security line staff work in eight-hour shifts, which include the following hours 0700-1500, 0800-1600, 0100-1800 and 1500-2100. A review of the PAQ further confirms that not all hours of the day are covered by a shift; however, based on the on-site tour, the Auditor accepts that the facility inadvertently did not report the shift that covers 2100-0100. An interview with the facility Administrator confirmed staffing levels are maintained with the use of voluntary overtime when needed. During the on-site audit, the Auditor observed and confirmed staffing levels at the facility were adequate. The facility has a total of (b) (7)(E) strategically located throughout the facility. (b) (7)(E) can be saved for up to 60 days. The Auditor observed live video footage while on-site. In addition, the Auditor observed the facility comprehensive supervision guidelines, which are stored and accessible to staff on the facility computer system. The guidelines had been updated in 2021 and 2022, indicating an annual review is occurring. In an interview with the Agency PSA Coordinator/SDDO the Auditor confirmed he reviews and approves the facility supervision guidelines on an annual basis. During an interview with the FA, it was indicated that in determining adequate levels of supervision and the need for video monitoring, the facility takes into consideration general accepted detention practices, any judicial finding of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incidents review reports, and any other relevant factors, including but not limited to the length of time detainees spend in OCCF's custody. However, the facility did not provide the Auditor with the facility staffing plan, and therefore, the Auditor could not confirm the existence of a staffing plan or that when determining adequate levels of detainee supervision or the need for video monitoring the facility considered all elements of subsection (c) of the standard.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. In an interview with the FA, it was indicated that in determining adequate levels of supervision and the need for video monitoring, the facility takes into consideration general accepted detention practices, any judicial finding of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incidents review reports, and any other relevant factors, including but not limited to the length of time detainees spend in OCCF's custody. However, the facility did not provide the Auditor with the facility staffing plan, and therefore, the Auditor could not confirm the existence of a staffing plan or that when determining adequate levels of detainee supervision or the need for video monitoring the facility considered all elements of subsection (c) of the standard. To become compliant the facility must develop and document a staffing plan which takes into consideration all elements required in subsection (c) of the standard.
(d): OCSO policy, Supervisor Rounds, states, "Sergeants assigned to housing areas will conduct a minimum of three (3) unannounced rounds of the units under their supervision during each shift. Shift Commander Rounds: All units and other areas of activity will be visited by a Shift Commander at least once a shift. During these unannounced rounds, the Shift Commander will observe conditions in all areas, inspect security and safety devices and practices, inspect all cells and review and sign logbooks. Log entries must be in red ink." A review of OCSO policy, Supervisor Rounds, confirms it does not require supervisors to identify and deter sexual abuse of detainees. In addition, OCSO policy, Supervisor Rounds, does not prohibit staff from alerting others when unannounced security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility. Interviews with

supervisor staff indicated unannounced rounds are occurring at the facility. Each supervisor interviewed confirmed the rounds occur at different times of the day or night to ensure the detainees and staff cannot determine a pattern of when the rounds occur. The Auditor reviewed facility logbooks. Supervisor rounds were noted in red ink and appeared to be frequently conducted on random days and shifts. However, the Auditor could not differentiate between unannounced PREA security inspections from regular supervisory rounds required as noted in OCSO policy. Security line staff and supervisors indicated the facility prohibits staff from alerting other staff that rounds are occurring.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. During the on-site tour, the Auditor reviewed facility logbooks. Supervisor rounds were noted in red ink and appeared to be frequently conducted on random days and shifts; however, the Auditor could not differentiate between unannounced PREA security inspections and regular supervisory rounds required by facility policy. To become compliant, the facility shall implement a procedure for security supervisors to conduct unannounced security inspections to deter sexual abuse from occurring. The procedure shall include requiring supervisors to document the unannounced security inspections in a way that will confirm unannounced security inspections are to identify and deter sexual abuse of detainees. Once the new procedure is implemented, the facility must submit documentation that all custody supervisory staff were trained on the procedure. The facility must submit to the Auditor facility logbooks for a period of one month during the corrective action plan (CAP) period to confirm the implementation of the new procedure.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b)(c)(d): OCSO policy, Classification, states, "The facility does not house ICE Detainees under 18 years of age." The Auditor reviewed a memo which states, "The Orange County Correctional Facility has not held any juveniles or family unit detainees during the current audit period." In addition, during interviews with the FA and PSA Compliance Manager, the Auditor confirmed the facility does not house juvenile or family detainee units for ICE.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(c)(d): OCSO policy, SAAPI, states, "Staff of the same gender as the inmates/detainees will perform pat searches. Only in exigent circumstances will cross gender pat searches be permitted. In such cases, the exigent need for the cross gender pat search will be made by the Shift Commander. In the event a cross gender pat search is conducted an Officer's Report will be generated articulating the circumstances and findings." Interviews with all security line staff and supervisors indicated that cross-gender pat-down searches are not conducted on detainees at OCCF. This was further supported by the facility PAQ and a memo to the file which states, "Be advised the Orange County Sheriff's Office does have a policy to conduct cross gender pat searches in emergency situations. The Corrections Division has not conducted any such searches during this audit cycle." During the on-site audit, the Auditor observed a pat-down search being conducted. The pat-down search was conducted by security staff of the same gender as the detainee.

(e)(f): OCSO policy, SAAPI, states, "All strip searches shall be performed by staff of the same gender as the inmate/detainee." The Auditor reviewed the facility General Strip Search/Clothing Exchange Report, utilized to document all strip searches that occur at the facility, and confirmed staff are required to list who conducted the search and the reason the strip search was conducted. The Auditor reviewed the facility Defensive Tactics training curriculum which states, "A body cavity search is a search that can only be conducted by medical professionals" and "under no circumstances are you authorized to conduct body cavity searches. Body cavity searches are to be conducted only on probable cause, by qualified medical professionals, under the order of a supervisor." Interviews with the PSA Compliance Manager, security line staff and supervisors confirmed, staff were aware cross-gender strip searches and visual body cavity searches can be conducted at the facility only by medical professionals. In an interview with the FA, it was confirmed no visual body cavity searches of detainees have been conducted at the facility during the audit period.

(g): OCSO policy, SAAPI, states, "Staff of the opposite gender may not visually observe inmates/detainees while changing clothing or showering unless within the scope of their duties. Staff of the opposite gender must also announce their presence upon entering the inmates/detainee living areas." A review of OCSO policy, SAAPI, confirms it does not include verbiage that prohibits opposite gender staff from viewing detainees while performing bodily functions except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. During the on-site audit, the Auditor observed all shower areas in the male and female detainee housing units. In the male detainee units, the showers are single showers with doors and in the female units, the showers are single showers with shower curtains. Both the doors and the curtains allow detainees to shower without being seen by staff of the opposite gender. Each individual cell had a toilet area, positioned next to the cell door. The position of the toilet allows detainees to perform bodily functions without being seen by staff of the opposite gender. During formal and informal interviews with detainees, all detainees reported they can shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender. In addition, they all reported the housing unit staff will announce when staff of the opposite gender enters the housing unit. This was also directly observed by the Auditor during the on-site audit.

Does Not Meet (g): The facility is not in compliance with subsection (g) of this standard. A review of OCSO policy, SAAPI, confirms it does not include verbiage that prohibits opposite gender staff from viewing detainees while performing bodily functions except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a

medical examination or monitored bowel movement. To become compliant, the facility must update OCSO policy, SAAPI, to include verbiage that prohibits opposite gender staff from viewing detainees while performing bodily functions except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Once updated, the facility must submit updated OCSO policy, SAAPI, to the Agency for review and approval.

(h): OCCF is not designated as a Family Residential Center; therefore, provision (h) is not applicable.

(i)(j): OCSO policy, SAAPI, states, "Booking Officers will contact Medical Staff in the event they cannot determine the gender of an inmate before conducting a search." OCSO policy, Pat Frisk, states, "All staff are trained in the techniques of pat frisking during Academy Training" and "if an inmate/detainee self identifies as transgender, gender non-conforming or intersex, the Officer, other sworn officer, or other qualified employee shall, absent exigent circumstances, offer the individual the option of choosing the gender of the Officer, other sworn officer, or qualified employee who will conduct the search." The Auditor reviewed the facility Defensive Tactic training curriculum which states, "Prisoner searches, must without exception, be conducted in a humane manner, least embarrassing or least intrusive as possible, while still being effective." A review of OCCF's training curriculum, training records, and interviews with security line staff, confirmed security line staff receive training in proper procedures for conducting pat-down searches, including cross-gender searches of transgender and intersex detainees, to conduct all pat searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs, including consideration of officer safety. During the on-site audit, there were no transgender/intersex detainees housed at the facility, and therefore, no transgender/intersex detainee interviews were conducted.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): OCSO policy, SAAPI, states, "In compliance with Federal law and DHS policy New York State Penal Law the facility takes reasonable steps to provide meaningful access to the facility's Sexual Abuse and Assault Prevention and Intervention Program for inmates/detainees with Limited English Proficiency (LEP). 1) The Orange County Correctional Facility makes available competent foreign language and sign language interpreters to ensure effective communication with inmates/detainees with LEP and disabilities (e.g., inmates/detainees who are deaf, hard of hearing or blind and inmates/detainees with low vision) during all aspects of the facility's efforts to fulfill this zero-tolerance policy. 2) A list of interpreters is available on the facility computer system, Jail Public. Under no circumstances will an inmate be used as an interpreter. 3) The GTL telephone translation machine for the hearing impaired is stored in the Command One storage closet. 4) Any inmate documented as hearing impaired at time of admission will be permitted access to the GTL telephone translation machine. 5) To obtain accommodations for inmates/detainees with a disability, facility staff will contact their immediate Supervisor." During interviews, Intake and security line staff advised the Auditor that upon intake, detainees are provided a document entitled "Inmate Orientation" which contains information on sexual abuse/assault, including treatment and counseling, prevention/intervention, and reporting sexual abuse and self-protections. Security line staff and Intake staff, explained to the Auditor the steps that are taken to effectively communicate with LEP detainees when necessary, including utilizing Pacific Interpreters and a Language Line Solutions Company. Intake and security line staff further indicated that a talk-to-text telephone (TTY) system service through Global Tel Link is utilized to communicate with detainees who are deaf or hard of hearing. For detainees who are LEP, the document is read to them utilizing the language line or a staff interpreter. Intake staff stated if a detainee had limited reading skills or was speech, intellectually or psychiatrically impaired, they would communicate the information on the same level as the detainee, so that they could understand. In addition to the Inmate Orientation document, the detainee is issued a tablet that contains the Inmate Orientation document, as well as facility policies, the facility handbook, the ICE National Detainee Handbook and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet. However, the Auditor reviewed the tablet and confirmed all documents are available in English and Spanish only. During the on-site audit the facility obtained the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE: Spanish, English, Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets in the 15 most prevalent languages encountered by ICE: English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading all languages onto the detainee tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, the Auditor could not confirm detainee accessibility while on-site. The Auditor further observed the orientation video and confirmed it was accessible in English and Spanish only. The Auditor also observed the DHS-prescribed sexual assault awareness notice, in English and Spanish, located in the intake area. The Auditor interviewed four detainees who arrived at the facility during the on-site audit. Three LEP detainees confirmed they were read the Inmate Orientation document, two reported it was read by a staff member and one reported it was read with the use of the language line; however, the fourth detainee reported nothing was read to him and he just signed the form. During interviews with 16 additional detainees, two detainees reported they understood PREA, their rights, how to report an incident of sexual abuse. The other 14 detainees interviewed indicated they did not understand what PREA was, what zero-tolerance meant, their rights, or that they could report an incident of sexual abuse in ways that don't include reporting it to a staff member.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. All PREA information is located on the detainee tablets; however, except for the facility handbook, which is also available in French, the PREA related information is available in English and Spanish only. During the on-site audit the facility obtained the ICE National Detainee Handbook in the 14 most

prevalent languages encountered by ICE: Spanish, English, Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets in the 15 most prevalent languages encountered by ICE: English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading all languages onto the detainee tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, the Auditor could not confirm detainee accessibility while on-site. In addition, in interviews with 20 detainees it was confirmed that 14 detainees were not able to articulate the meaning of PREA, zero-tolerance, or ways to report an allegation of sexual abuse in ways other than to staff. To become compliant, the facility must implement a practice that ensures that all detainees can participate in or benefit from all aspects of the Agency's efforts to prevent, detect and respond to sexual abuse, including detainees who are LEP. In addition, the facility must provide all detainees access to the PREA information included in the facility handbook, ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet, in a manner they understand. Once implemented, all intake staff must receive documented training on the new practice. The facility must provide the Auditor with 15 detainee files consisting of detainees who speak a language other than English, Spanish, or French to confirm implementation of the new practice.

(c): OCCF's SAAPI states, "Under no circumstances will an inmate be used as an interpreter." In interviews with security line staff and supervisors, it was confirmed that the facility would not utilize a detainee for interpretation under any circumstances.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. OCSO policy, SAAPI, requires "under no circumstances will an inmate be used as an interpreter." Interviews with security line staff and supervisors, confirmed that they would not use a detainee to interpret under any circumstances. To become compliant, the facility must implement a practice of allowing the use of another detainee in matters related to sexual abuse should the detainee express a preference for another detainee to provide interpretation and the Agency determines such interpretation is appropriate and consistent with DHS policy. In addition, the facility must train all security line staff and supervisors on the updated practice and provide training records to confirm the training was conducted during the CAP period. The facility must submit updated OCSO policy, SAAPI, to the Agency for review and approval.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." ICE Directive 6-7.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." During a training session in November 2021, and through review of the training documentation available on SharePoint, the Unit Chief of OPR PSO explained that all ICE staff having contact with detainees must clear a background investigation through PSO before hiring. The staff complete an Electronic Questionnaire for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE. The Auditor submitted five ICE staff to PSO to verify the background check process. ICE PSO confirmed the investigation status of all five ICE staff prior to hiring and every five years, thereafter, as required by the standard. OCSO policy, Personnel, states, "Each candidate for a position Sworn or Civilian within the Corrections Division shall be subjected to an extensive background investigation. This investigation shall include, but is not limited to, a Mental Hygiene check, Credit Bureau check, Criminal Background check, personal and business reference check, past employment; military check, any incidents of engaging in sexual abuse in the workplace or any jail, lock up, community confinement facility, juvenile facility or other institution, as defined in 42 U.S.C. 1977, or any resignation of a pending investigation of an allegation of sexual abuse shall be deemed disqualified from the position within the Corrections Division, has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse or has been civilly or administratively adjudicated to have engaged in the activity described in paragraph of this section." OCSO policy, Personnel, further states, "The facility maintains a current, confidential personnel record on each employee. The NYS License Event Notification Service (LENS) and eJusticeNY continually monitors staff and contractors and alerts the Agency of any background status changes." OCSO policy, Security Clearances and Facility Access, states, "When a contractor hires a new employee, they must complete the Orange County Correctional Facility Notice of New Hire form, pedigree form and a Background Investigation Form. The contractor will then forward the form to Programs and the Security Captain. All contractor hires will be subject to a fingerprinting and criminal history background check before administrative approval is granted for access to the facility" and "all persons requesting to work as volunteers will be subject to a background check, to include the submission of fingerprints to the Investigations Unit and an interview with the Programs Sergeant prior to being registered. All findings from the Identification Unit and the Programs Sergeant will be forwarded to the Security Captain for review so a determination can be made as the facility access approval or denial." The Auditor reviewed the "Applicant Integrity Warning" form and confirmed perspective employees are required to read and sign the document which states, "Any evasive,

misleading or untruthful statement given to any employee of the Orange County Sheriff's Office; or any failure to disclose and provide information; or any failure to follow instructions given to me by my background investigator or any other employee of the Orange County Sheriff's Office designated to give me instructions; or engaging in any other act that is evasive, misleading or untruthful in nature during the course of my background investigation may result in the termination of my background investigation and/or removal of my name from the eligibility list for failing to meet the required integrity thresholds." During an interview with HR staff, the Auditor confirmed all staff, contractors and volunteers undergo a background check prior to employment. All staff are entered into New York State Department of Criminal Justice LENS. Through LENS the facility is notified anytime the employee/contractor has police contact, and therefore, acts as a continuous background check for OCCF staff. Entry into the system remains active until such time as there is a separation of the parties. The Auditor reviewed the system and confirmed entry of the employee/contractor's name, date of birth, social security number, agency of employment, job title, date of entry and status (full-time, part-time, or inactive). During the file review of eight employees, the Auditor confirmed entries into the system were made prior to the employee/contractor hiring date. However, the Auditor's review of the personnel records, nor the HR staff interview, could not confirm that that facility imposed upon the employee a continuing duty to disclose misconduct related to sexual abuse. An interview with HR staff, confirmed that material omissions regarding misconduct or false information is grounds for disqualification, termination, or withdrawal of an offer of employment. In addition, the facility HR staff, indicated during the hiring process an interview panel will meet with the candidate. During this interview, the candidate is asked if they have ever worked in a correctional type setting; (If candidate answered yes to #1) have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution; have you ever 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 unbale to consent or refuse; have you been civilly or administratively disciplined for any type of sexual misconduct; and have you ever been accused or disciplined for incidents of sexual harassment. The Auditor reviewed files for eight employees that were hired at the facility during the audit period. Any Candidate that answered no to question one was not asked if they have ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution. One candidate reported previous correctional experience and was asked the question. The Auditor confirmed, by review of the employee's personnel file, that during the background process, the facility contacted the candidate's past employer to obtain information on substantiated allegations of sexual abuse or resignation during a pending investigation. In addition, the Auditor reviewed the application of a candidate for hire who failed to disclose previous sexual abuse during the hiring process and confirmed the facility immediately disqualified the candidate. According to HR staff, the facility has not had any staff promotions, during the audit period; however, they would be asked about any previous misconduct during the promotion interview.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. During employment interviews, the candidate is asked if they have ever worked in a correctional type setting; (If candidate answered yes to #1) have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution. If the candidate does not have previous correctional experience, the interview panel will not ask if they have ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution. (As defined in 42 U.S.C. 1997, an institution is a facility or institution which is owned, operated, or managed by, or provides services on behalf of any State or political subdivision of the state and which is for persons who are mentally ill, disabled or retarded or chronically ill or handicapped; a jail or prison or correctional facility; a pretrial detention facility.) In addition, the facility provided no documentation to indicate that the staff have a continuing duty to disclose misconduct related to sexual abuse. To become compliant, the facility shall implement a practice to ask all candidates all questions regardless of past correctional experience. The facility shall provide the Auditor with documentation that at least 10 candidates were asked all questions during the hiring interview. In addition, the facility shall implement a practice that requires staff acknowledgement of the continuing affirmative duty to report any misconduct involving sexual abuse and provide documentation of the employee's understanding of the implemented practice.

(f): During an interview, HR staff indicated that NY State law requires the employee to sign a release of information, prior to providing information to another agency. Employment information is given, such as dates of employment, reason for separation, h0wever, NY State Law prohibits the release of information regarding internal investigations.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): According to the PAQ, and an interview with the facility Administrator, it was confirmed that during the audit period there have been no acquisitions, expansions, or modifications to any areas in the facility where detainees are allowed to enter, nor has there been any updates to the video monitoring system, , therefore, subsections (a) and (b) of the standard are not applicable.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

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

OCSO policy, SAAPI, states, "In all cases of sexual assault, abuse and misconduct, the Orange County Correctional Facility conducts its own investigation into the incident or allegation of sexual abuse." OCSO policy, SAAPI, further states, "At any point where the circumstances of an incident clearly indicated that a crime has been committed by a staff member, the case will be immediately turned over to the Professional Standards and Compliance Office for action, and the Undersheriff will be advised" In addition, OCSO policy, SAAPI, states, "As appropriate to the event, the victim by act of sexual abuse, assault or any sexual mistreatment shall be referred, under appropriate security provisions to Orange County Regional Medical Center for treatment. Gathering of clinical forensic evidence shall be conducted by a Sexual Assault Nurse Examiner. If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member shall be permitted to accompany and support the victim through the forensic medical examination and investigatory interviews to provide emotional support, crisis intervention, information, and referrals." OCSO policy, SAAPI, further states, "At no cost to the inmate/detainee, the facility administrator shall arrange for the victim to undergo a forensic medical examination." The Auditor reviewed a memorandum to the file, which states, "Sexual Assault Nurse Examiner (SANE) exams are conducted at the Orange County Regional Medical Center (OCRMC)." During the on-site audit, the Auditor observed detainees are provided access to victim advocate services through the Orange County Rape Crisis Center (OCRCC.) Detainees can access the service by speed dialing #33 from the detainee tablets. The Auditor tested the system and spoke with an advocate and confirmed services are provided to the detainees at no cost and if a detainee is the victim of a sexual assault the detainee would be taken to the OCRMC for a SANE exam. The advocate further confirmed the OCRCC would be notified and would accompany the detainee to provide emotional support during the exam. The Auditor reviewed a Memorandum of Understanding (MOU) between Mental Health Association in Orange County (MHA), OCRCC, and OCCF. The MOU lays out the responsibilities of OCRCC, which include providing phone advocacy, responding to calls made by hospital personnel for incarcerated individuals who present in the hospital, provide emotional support and referral information during an investigation, and conduct trainings for law enforcement in regard to sexual assault services. The Auditor interviewed an OCJ nurse who confirmed treatment would always be with the detainee's consent. The Auditor reviewed OCSO policy, SAAPI, and confirmed that the evidence protocol maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. An interview with a facility Investigator, confirmed the facility would investigate using a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence and if it is determined that the allegation is criminal in nature, the investigation would be turned over to the Professional Standards and Compliance Office (PSCO). The PSCO is part of the Orange County Sheriff's Office and therefore, is required to follow the requirements of subsections (a-d) of the standard.

Recommendation (c): The Auditor recommends that the facility update OCSO policy SAAPI to include treatment would only be provided upon the detainee's consent.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." OCSO policy, SAAPI, states, "A prompt, thorough, objective and fair investigation shall be conducted into all allegations, including third party and anonymous reports of sexual abuse or assault." OCSO policy, SAAPI, further states, "In cases that involve an ICE Detainee, the Corrections Administrator shall coordinate as necessary with the ICE Office of Professional Responsibility (OPR) and/or criminal investigative entities responsible for the investigation of the incident." A review of OCCF policy, SAAPI, confirms it does not require the documentation of all reports and referrals of allegations of sexual abuse be maintained for at least five years. In addition, OCSO policy, SAAPI, does not require that all incidents of sexual abuse be reported to the Joint Intake Center (JIC), the DHS Inspector General's Office (OIG), or the appropriate ICE FOD. The Interviews with the FA and the PSA Compliance Manager confirmed the facility will conduct an administrative investigation into all allegations of sexual abuse. If the allegation is criminal, the PSCO will conduct a criminal investigation. All allegations of sexual abuse are immediately reported to the SDDO and the Field Office Director. Interviews with Investigators confirmed all investigation reports and referrals are maintained in accordance with the standard.

Does Not Meet(a)(b)(e)(f): The facility is not in compliance with subsections (a), (b), (e), and (f) of the standard. The facility has established a protocol, OCSO policy, SAAPI, as required by subsection (a) of the standard; however, a review of OCSO policy, SAAPI, confirms it does not require the documentation of all reports and referrals of allegations of sexual abuse be maintained for at least five years or the requirement to notify the JIC, DHS OIG, or the appropriate FOD of any incidents of sexual abuse. Interviews with the FA and the facility PSA Compliance Manager indicated that all incidents of sexual abuse are reported to the SDDO and the Field Office Director; however, the subsections (e) and (f) require that the facility must ensure that all incidents are promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General. To become compliant, the facility shall develop and implement a reporting procedure that ensures that, in addition to reporting an incident of sexual abuse to ICE OPR, the facility will notify the JIC, ICE Office of Professional Responsibility or DHS OIG, and the appropriate ICE Field Office Director. In addition, the facility shall revise the facility protocol to include the requirement of documentation and maintenance, for at least five

years, of all reports and referrals of allegations of sexual abuse. Once the revisions to the protocol have been made, the facility shall train all investigative staff on the updated protocol. Documentation of the revision and the training shall be provided to the Auditor. If applicable, the facility must provide the Auditor with all sexual abuse investigation files that occurred during the CAP period to confirm that the allegations have been referred to JIC, ICE OPR, the DHS OIG, and the appropriate ICE Field Office Director.

(c): During the Auditor's review of the OCCF's website (https://www.orangecountygov.com/511/Corrections-Jail) it was confirmed that the website does include the OCSO policy, SAAPI; however, a review of OCSO policy, SAAPI confirms it is not compliant with the standard; and therefore, the uploaded policy on the website, is not compliant. The Auditor also reviewed the ICE website (https://www.ice.gov/prea) and confirmed the required Agency protocol is available.

Does not meet (c): The facility is not in compliance with subsection (c) of the standard. OCSO policy, SAAPI, is posted on the facility website; however, a review of OCSO policy, SAAPI, confirms it is not compliant with the requirements of the standard; and therefore, the uploaded policy on the website, is not compliant. To become compliant, the facility must post the updated OCSO policy, SAAPI, on the facility website.

§115.31 - Staff training.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "All facility staff receives Sexual Abuse and Assault Prevention training during the initial orientation course and an annual refresher course thereafter." OCSO policy, SAAPI, further states, "The facility PREA Coordinator and Training Unit Supervisor shall maintain documentation verifying employee, volunteer and contractor training." Training is documented with training Sign In-Sheets at the beginning of training and a PREA Acknowledgment at the end of training." The Auditor reviewed the PREA Acknowledgment and confirmed it includes a statement which states, "I fully understand my responsibilities and duties as it pertains to detection, prevention and reporting possible PREA incidents within the facility." The Auditor reviewed the facility PREA training curriculum and confirmed the curriculum includes the facility's zero tolerance policy, definitions and examples of prohibited and illegal sexual behaviors and procedures for reporting knowledge or suspicion of sexual abuse; however, the curriculum does not contain the Agency's zero tolerance policy, the right of detainees and staff to be free from sexual abuse and from retaliation for reporting on the examples of prohibited and illegal sexual behaviors, 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 lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees, 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. In an interview with the facility PSA Compliance Manager, it was indicated that staff are required to attend PREA training prior to their initial hire and every year thereafter. During interviews with security line staff, they were confident in discussing the facility zero-tolerance policy. They could articulate how detainees can report an allegation and their own reporting responsibilities; however, the security line staff struggled with articulating some of the signs of sexual abuse, communicating with transgender and intersex detainees in an effective and professional manner and knowledge of staff and detainees to be free from retaliation for reporting, or cooperating with an investigation into sexual abuse. The Auditor randomly selected 14 employees' files for review, 12 were staff hired during the audit period and two were staff employed at the facility prior to May 6, 2014. The Auditor confirmed each file contained a training Sign In-Sheet and the PREA Acknowledgment form with a staff signature. The Auditor also reviewed the ICE PREA employee training for five ICE employees, which contained all elements required by this standard; however, no documentation was provided to indicate that the five ICE employees attended the Agency training. Documentation was provided that confirmed all five ICE employees had attended the mandatory OCCF training; however, the OCCF training lacked all required elements of the standard.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. The facility training curriculum does not contain the required elements of the Agency's zero tolerance policy, the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on the examples of prohibited and illegal sexual behaviors, 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 lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees, 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. In addition, the Auditor reviewed the ICE PREA employee training for five ICE employees, which contained all elements required by this standard; however, no documentation was provided to indicate that the five ICE employees attended the Agency training. To become compliant, the facility shall revise the PREA training curriculum to include all elements of this standard. Once the curriculum has been revised, the facility shall ensure that all facility staff are trained on the updated curriculum. In addition, the facility must forward documentation of the training completed during the CAP period for 20 OCCF staff. The facility must document that the five ICE staff have received PREA training as required by the standard.

§115.32 - Other training.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "The facility PREA Coordinator and Training Unit Supervisor shall maintain documentation verifying employee, volunteer and contractor training." According to an interview with the PSA Compliance Manager contractors attend training with facility staff. The Auditor observed the training curriculum, which is the same curriculum used to train the facility staff. The training includes the facility's zero tolerance policy regarding sexual abuse and informs the employee how to report such incidents; however, the training does not include the Agency's zero-tolerance policy. The facility provided to the Auditor sign in sheets for medical and mental health staff; however, medical, and mental health staff do not provide services on a non-reoccurring basis as defined by subpart (d) of the standard. According to the PAQ and an interview with the Volunteer Coordinator the facility does not have volunteers currently working in the facility. Therefore, no interviews were completed with volunteers.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. The Auditor reviewed the PREA training curriculum and confirmed that the training does not include the Agency's zero-tolerance policy regarding sexual abuse. To become compliant the facility shall revise the PREA Training Curriculum to include the Agency's zero tolerance policy. In addition, the facility shall train all contractors who provides services on a non-reoccurring basis to the facility utilizing the revised training curriculum and provide the Auditor documentation such training.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "Upon admission to the facility, all inmates/detainees shall be notified of the facility's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and inmate/detainee handbook and provided with information about the facility's Sexual Abuse and Assault Prevention and Intervention Program. Such information shall include, at a minimum: the facility's zero tolerance policy for all forms of sexual abuse or assault; the name of the facility PREA Coordinator, and information about how to contact him/her; prevention and intervention strategies; definitions and examples inmate-on-inmate sexual abuse, staff-on-inmate sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including the DHS/OIG and the ICE/OPR investigation processes for ICE detainees, and right of detainees to report an incident or allegation of sexual abuse, assault, or intimidation to any staff member at the facility and to ICE/DHS; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of an inmate/detainee, who has been subject to sexual abuse or assault, to receive treatment and counseling." Formal and informal interviews with Intake staff, in conjunction with Auditor observations of a video recording of the intake process, confirmed detainees are provided a document, Inmate Orientation. A review of the Inmate Orientation Document confirms it contains information on sexual abuse/assault, including treatment and counseling, prevention/intervention, reporting sexual abuse and self-protections during the intake process; however, the document does not provide information on how to report an allegation of sexual abuse to the DHS OIG or the JIC. In addition, it does not inform the detainee of the Agency's zero-tolerance policy, that retaliation, including reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, is prohibited, or definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual abuse. Interviews with Intake staff further indicated, if detainees are LEP, visually impaired, have limited reading skills, or otherwise disabled, the staff will read the document to the detainees and will use the language line or a staff interpreter, if needed. If the detainee is deaf, he/she can read the document, and if not in the language they can understand, they will use the sign language line to communicate the information to the detainee. Intake staff stated if a detainee were intellectually or psychiatrically impaired, they would communicate the information on the same level as the detainee, so that they could understand. All detainees are requested to answer yes or no, indicating they understand each section of the Inmate Orientation and to document the receipt of the facility rulebook and the ICE National Detainee Handbook. The detainees are not given a copy of the Inmate Orientation, however a blank copy is made continually available on the detainee tablets, in both English and Spanish. In addition, the facility handbook, available in English, Spanish, and French, the ICE National Detainee Handbook and DHS-prescribed Sexual Abuse and Assault (SAA) Information pamphlet, available in English and Spanish, are also continually available and can be accessed on the tablets. However, in addition to the ICE National Detainee Handbook not being available in the 12 of the 14 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets not being available in the 13 of the 15 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, during an interview with the disciplinary officer it was confirmed that should a detainee receive a misbehavior report, facility sanctions include, the confiscation of the detainee's tablet for up to seven days, thus, prohibiting them from having access the PREA information available on the detainee tablet. At intake, detainees are asked to sign the Inmate Orientation document and acknowledge that they have received a copy of the facility rulebook and the ICE National Detainee Handbook. The Inmate Orientation states, "Inmate did receive a copy of the Inmate Rulebook. Yes or no and includes the statement, "You will be issued a tablet which contains the most recent version of the facility rulebook and the National Detention Handbook." The Auditor interviewed 20 ICE detainees, which included 4 of the detainees, that had arrived at the facility the night prior to the interview. Each detainee was asked if they remembered receiving information about sexual abuse, such as how to stay safe or how to report an incident. Eleven detainees responded they did not receive this information and eight stated they did. One detainee interview could not be completed and therefore no response was indicated. The Auditor reviewed 15 detainee files. All 15 detainee files contained the Inmate Orientation document, which had been signed by each detainee on the day of the detainee's intake into the facility; however, the signed document did not confirm that the detainee received the Inmate Orientation document, or other provided PREA information in a manner that they could understand. During the on-site audit the facility obtained the ICE National Detainee

Handbook in the additional 12 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets in the additional 13 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading all languages onto the detainee tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, the Auditor could not confirm detainee accessibility while on-site.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), (c), and (d) of the standard. During the intake process, detainees are not provided an Orientation program that provides the detainees information on how to report an allegation of sexual abuse to the DHS OIG or the JIC, Agency's zero-tolerance policy, that retaliation, including reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, is prohibited, or definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual abuse as required by the standard. The facility handbook, available in English, Spanish, and French, the ICE National Detainee Handbook, and DHS-prescribed SAA Information pamphlet, available in English and Spanish, are continually available and can be accessed on the tablets. However, in addition to the ICE National Detainee Handbook not being available in the 12 of the 14 most prevalent languages encountered by ICE: Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, and Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali and the DHS-Prescribed SAA Information pamphlets not being available in the 13 of the 15 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, during an interview with the disciplinary officer it was confirmed that should a detainee receive a misbehavior report, facility sanctions include, the confiscation of the detainee's tablet for up to seven days, thus, prohibiting them from having access the PREA information available on the detainee tablet. A review of 15 detainee files contained the Inmate Orientation document, which had been signed by each detainee on the day of the detainee's intake into the facility; however, the signed document did not confirm that the detainee received the Inmate Orientation document, or other provided PREA information in a manner that they could understand. To become compliant, the facility must implement an intake orientation program that ensures that all detainees can participate in and benefit from all aspects of the Agency's efforts to prevent, detect and respond to sexual abuse, including detainees who are LEP. In addition, the facility must provide all detainees access to the PREA information included in the ICE National Detainee Handbook, and a copy of the DHS-prescribed SAA Information pamphlet, in a manner they understand; and ensure that the access be available at all times in at least one constant means should the detainee's tablet be confiscated when sanctioned for breaking a facility rule. Once implemented, all intake staff must receive documented training on the new practice. In addition, the facility must provide the Auditor with 10 detainee files consisting of detainees who speak a language other than English, Spanish, or French to confirm the new process has been implemented.

Recommendation: In review of the Inmate Orientation, the term inmate is used instead of detainee and the Auditor is making a general recommendation to update the Inmate Orientation throughout to reflect detainee.

(d)(e)(f): During an interview with the SDDO, the Auditor confirmed the DHS-prescribed SAA Information pamphlet is available for the detainees on the detainee tablets; however, in Spanish and English only. During an interview with the disciplinary officer, it was confirmed that should a detainee receive a misbehavior report one sanction used by the facility is to confiscate the detainee's tablet for up to seven days, thus, prohibiting them from having access to the DHS-prescribed SAA Information pamphlet. During the on-site audit, the SDDO had obtained the DHS-prescribed SAA Information pamphlet in the 13 unavailable most prevalent languages encountered by ICE: Arabic, Bengali, Chinese, French, Vietnamese, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Turkish, and Ukrainian and the ICE National Detainee Handbook in the additional 12 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and was in the process of uploading the additional languages on the tablets; however, the upload had not been completed prior to the Auditor leaving the facility, and therefore, detainee accessibility could not be confirmed. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice which included the name of PSA Compliance Manager, and the contact information for OCRCC in English and Spanish only, in the intake area; however, the notices were not observed posted on any of the housing unit bulletin boards. Informal interviews with facility security line staff, indicated, detainees are provided a tablet, prior to entering the housing unit; however, the standard requires the information be posted. The Auditor reviewed the ICE National Detainee Handbook and confirmed it contains information about reporting sexual abuse; however, the ICE National Detainee Handbook was only made available to the detainees in English and Spanish.

Does Not Meet (d)(e)(f): The facility is not in compliance with subsection (d), (e) and (f) of the standard. During the on-site audit, the Auditor did not observe the DHS-prescribed sexual assault awareness notice or the contact information for OCRCC posted on the bulletin boards in the housing units. The DHS-prescribed sexual assault awareness notice and contact information for OCRCC was located on the detainee tablet; however, the information was only accessible in English and Spanish. A review of the detainee tablet further confirmed that the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet were uploaded on the detainee tablets; however, in English and Spanish only. In an interview with the disciplinary officer, it was confirmed that should a detainee receive a misbehavior report one sanction used by the facility is to confiscate the detainee's tablet for up to seven days, thus, prohibiting them from having access to the DHS-prescribed SAA Information pamphlet. A review of 15 detainee files contained the Inmate Orientation document, which had been signed by each detainee on the day of the detainee's intake into the facility; however, the signed document did not confirm that the detainee received the Inmate Orientation document, or other provided PREA information in a manner that they could understand. To become compliant, the facility must provide the detainees, the DHS-prescribed SAA Information pamphlet in a manner all detainees can understand. In addition, the facility must provide the Auditor with documentation

that confirms the DHS-prescribed SAA Information pamphlet, in the 15 most encountered languages by ICE, and the ICE National Detainee Handbook, in the 14 most encountered languages encountered by ICE, are available to all detainees either through the detainee tablet or by distribution; and, that should a detainee receive a misbehavior report the facility will not confiscate the detainee tablet, thus, prohibiting them from having access to the PREA information uploaded on the detainee tablet. The facility must provide the Auditor with 15 detainee files that include detainees who do not speak English, French, or Spanish to confirm that the required PREA information, and intake orientation, is provided to the detainee in a manner that he/she can understand.

§115.34 - Specialized training: Investigations.

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

Notes:

(a)(b): The Agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement." OCSO policy, SAAPI, states, "All facility staff responsible for conducting sexual abuse or assault investigations receives specialized training in conducting such investigations, which includes techniques for interviewing sexual abuse victims, sexual abuse evidence collection, and the criteria and evidence required for administrative action or prosecutorial referral." In addition, OCSO policy, states, "In all sexual abuse investigations, Sheriff's Investigators that have received special training in sexual abuse investigations shall be utilized." Interviews with a facility investigator and the facility PSA Compliance Manager indicated all investigators have completed the specialized training on sexual abuse and cross-agency coordination entitled "PREA Investigating Sexual Abuse in a Confinement Setting" offered by the National Institution of Corrections (NIC). The Auditor reviewed the curriculum and confirmed it contains all elements required by this standard. The facility PAQ stated the facility had 12 investigators on-site that have attended specialized training. The Auditor reviewed training certificates for 6 of the investigators, confirming they have attended the NIC training. In addition, the Auditor reviewed two sexual abuse investigation files and confirmed both investigators received specialized training as required by the standard.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

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

(b)(c): OCSO policy, SAAPI, states, "All full and part-time medical and mental health care practitioners who work regularly in the facility shall receive specialized training in detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse, responding effectively to victims of sexual abuse and assault, and reporting allegations of suspicions of sexual abuse or assault." In an interview with the HSA, and Mental Health Director it was indicated that medical and mental health staff have received specialized training through WellPath. The HSA provided documentation to the Auditor that confirmed medical and mental health staff have received the offered specialized training; however, the Auditor was not provided the training curriculum, and therefore, could not confirm all elements required by the standard are included in the training. In an interview with the SDDO, the Auditor confirmed OCSO policy, SAAPI, has been submitted to the Agency for review and approval.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. The Auditor was able to confirm that medical and mental health staff have received specialized training through WellPath; however, the facility did not provide the training curriculum to the Auditor, and therefore, the Auditor could not confirm all elements required by the standard are included in the WellPath training received by medical and mental health staff. To become compliant, the facility shall provide the training curriculum for specialized medical and mental health training. If non-compliance is determined, the facility must revise the training curriculum to include all elements of the standard and provide documentation that all medical and mental health staff have been trained on the revised curriculum.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): OCSO policy, SAAPI, states, "All inmates/detainees are screened upon arrival at the facility for potential risk of sexual victimization or sexual abusive behaviors and are housed to prevent sexual abuse or assault. In addition to the intake screening upon arrival all inmates will receive follow-up screenings by medical and mental health staff. Any department that finds an inmate to be a PREA risk will enter an alert in the Jail Management System and the facility Black Creek computer system. Any inmate found to be a PREA risk will be referred to Mental Health for a follow up." OCSO policy, SAAPI, further states, "Each new inmate/detainee is kept separate from the general population until he/she has been classified and may be housed according to such classification." OCSO policy, Classification, states, "ICE Detainees will be assigned housing based on the ICE Classification criteria. Detainees are classified by ICE Officials as follows: low, medium low, medium high or high." During formal and informal interviews with Intake staff,

Classification staff, and the PSA Compliance Manager, the Auditor confirmed all new arrivals of ICE detainees are kept separate from the general population until they are classified, and housing can be determined. Each detainee is assessed utilizing the facility Sexual Violence/Risk Assessment Screening form. The initial intake screening to assess risk for sexual victimization is completed by intake staff. The facility Sexual Violence/Risk Assessment Screening form asks the following questions: does physical stature create a potential for victimization; under the age of 20 or over the age of 60; has the inmate/detainee been the victim of sexual abuse; has the inmate/detainee ever been attacked in a jail or prison by other inmates/detainees; does the inmate/detainee know anyone within this facility that would be a threat to their safety; is this the first incarceration; does the inmate/detainee appear to have any of the following conditions: mental health problems, physical disability, development disability; does the inmate/detainee self-report to be the following: homosexual, bisexual, transgender, intersex; during the screening does the inmate/detainee behave in any of the following manners: intimidated, nervous, timid, fearful, isolated or withdrawn; does the inmate/detainee view him/herself as being vulnerable to sexual assault in the facility; current charge of sexual assault; current charge of sexual abuse of a child or elderly person or any other sex offense. If the detainee score is 4 or higher the detainee is referred to mental health. Classification staff complete the risk for abusiveness portion of the assessment after the detainee has been assigned to a housing unit. The risk for abusiveness form includes the following questions: violent criminal history; previous convictions of sexual abuse of a child or elderly person or any other sex offenses; past OCCF institutional disciplinary history of prohibited sexual acts; pending sexual charges; prior history of mental illness, hostile relationships with inmates, attempts at self-injury, suicide or has been on suicide watch, mental or physical handicapping conditions, assaulting behavior with staff, history of detention or incarceration, criminal history past or present, present or past history of escape or attempt. If the detainee scores 4 or higher they are referred to mental health. During interviews with Classification staff and the facility PSA Compliance Manager, the Auditor confirmed ICE detainees are housed based on the classification level assigned by ICE. The Classification staff can override the classification if the detainee is at risk for suicide or Classification staff discovers additional criminal convictions, not considered by ICE. Classification staff further indicated, the results of the initial screening are not considered and would not change the detainee's classification level and that the initial classification of the detainee is completed within twenty-four hours. The Auditor reviewed 15 detainee files; each file contained the completed Sexual Violence/Risk Assessment Screening form. The Auditor determined the risk for victimization was completed at the time of the intake of the detainee, however; the Auditor was unable to determine if the risk for abusiveness was completed by the Classification staff within twelve hours of the intake, as the form does not provide a time of completion. The Auditor formally interviewed 20 ICE detainees. All but one detainee reported the only questions asked during intake, was their name and date of birth. The 19 detainees further indicated they were not asked about previous sexual abuse or if they identify as lesbian, gay, bisexual, transgender, or intersex.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. During interviews with Classification staff and the facility PSA Compliance Manager, the Auditor confirmed ICE detainees are housed based on the classification level assigned by ICE. The Classification staff further indicated they can override the classification if the detainee is at risk for suicide or they discover additional criminal convictions that had not been considered by ICE; however, the results of the initial risk screening are not considered and would not change the detainee classification level assigned previously by ICE. In addition, Classification staff indicated that the initial classification is completed within twenty-four hours. The Auditor reviewed 15 detainee files; each file contained the completed Sexual Violence/Risk Assessment Screening form completed at the time of intake; however, the Auditor was unable to determine if the risk for abusiveness was completed by the Classification staff within twelve hours of the intake, as the form does not provide a time of completion. The Auditor formally interviewed 20 ICE detainees. All but one detainee reported the only questions asked during intake, was their name and date of birth. To become compliant, the facility must implement a practice requiring the facility to consider the information obtained during the initial risk screening to ensure the necessary steps are taken to mitigate any dangers identified in the assessment when determining a detainee's initial housing. In addition, the implemented practice must include the requirement to complete the initial classification process within twelve hours of admission into the facility. The facility must submit documentation of all intake and classification staff on the updated process. The facility must also provide the Auditor with 10 detainee files to confirm that the information obtained during the initial risk screening to ensure the necessary steps are taken to mitigate any dangers identified in the assessment when determining a detainee's initial housing and that the initial classification was completed within twelve hours of admission.

(e): OCSO policy, Classification, states, "All active files will be re-classified every 90 days or earlier, if necessary, in accordance with New Your State Commission of Correction Minimum Standards, §7013.9, §7003.2 and §7003.3. ICE detainees may request a reassessment of their classification 60 days after arrival at the facility." An interview with Classification staff confirmed a detainee 's risk for victimization or abusiveness is reassessed between 60-and-90 days from the date of the initial assessment, or earlier, if requested by the ICE detainee, or if additional information is received, such as following an incident of sexual abuse that would warrant a reassessment. The Auditor reviewed 15 randomly selected detainee files. In seven of the files, the reassessment occurred between 60-and-90 days, three files indicated that the assessment occurred after 90 days, and five files indicated the detainee had recently arrived at the facility and was not within the time frame to conduct the reassessment. In addition, the Auditor reviewed two investigations, and confirmed in one of the investigations the detainees (victim and alleged perpetrator) had left the facility prior to a reassessment and in the other investigation both detainees had received an assessment within 30 days of the alleged incident.

Does Not Meet: (e): The facility is not in compliance with subsection (e) of this standard. The Auditor reviewed 15 randomly selected detainee files. In seven of the files, the reassessment occurred within 90 days, three files indicated that the assessment occurred outside of the 90-day time frame and five files indicated the detainee had recently arrived at the facility and was not within the time frame to conduct the reassessment. To become compliant, the facility must ensure that each detainee's risk of victimization

or abusiveness is reassessed between 60-and90 days from the date of the initial assessment. If applicable, the facility must provide the Auditor with 10 detainee files to confirm that the detainees were reassessed within 60-and-90 days of the initial assessment.

(f): Interviews with Intake staff and Classification staff, indicated that if a detainee refused to answer, or not disclose, the requested information, the detainee would be placed on a one-on-one suicide watch and referred to mental health staff to ensure the safety of the detainee.

Does Not Meet (f): The facility is not in compliance with subsection (f) of the standard. An interview with Classification staff indicated that if a detainee refused to answer, or not disclose information, the detainee would be segregated and placed on a one-on-one suicide watch until seen by mental health staff. To become compliant, the facility must develop and implement a procedure to ensure detainees are not disciplined by placing them in a segregated one-on-one suicide watch for refusing to answer questions asked during the intake screening. Once the procedure is established, the facility shall train all Intake and Classification staff on the established procedure. Documentation of the development of the procedure and training of the Intake and Classification staff shall be forwarded to the Auditor. If applicable the facility shall provide the Auditor with any detainee files that include a detainee who refused to answer questions asked during the intake screening to confirm implementation of the new process.

(g): An interview with Intake staff, indicated Sexual Violence/Risk Assessment Screening is not stored on the computer. All detainee intake documentation is placed into a folder to be submitted to the Classification staff for completion. This includes the Sexual Violence/Risk Assessment Screening. The folders are kept on the intake desk, until picked up by Classification staff, in full view of all intake staff; however, according to Intake staff the risk assessment is in the backend of the paperwork so as not to be viewed by others.

Does Not Meet (g): The facility is not in compliance with subsection (g) of this standard. The facility has not implemented appropriate controls to prevent the dissemination of sensitive information gathered through responses to the intake screening. The completed screening is placed into a folder for Classification staff to pick up at a later time. The folders are kept on the officer's desk allowing anyone in the intake area to access the detainee folder. To become compliant, the facility must implement appropriate controls to prevent those that do not need to know, access to the sensitive information gathered through responses to the intake screening.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): OCSO policy, Classification, states, "Information will be taken into consideration when classifying inmates and detainees. NYS Suicide Screening Form and Sexual Violence/Risk Assessment Screening Form will be utilized to elicit and record information on each inmate relating to the following: visible injury/injuries on the inmate; medical conditions requiring immediate treatment; mental or physical handicap(s); history of mental illness or treatment; Potential for self-injury or suicide; history of detention or incarceration, including but not limited to hostile relationships with other inmates; medication currently being taken, present appearance and behavior; evidence of intoxication by alcohol or drugs or a history of alcohol or substance abuse, criminal charges and convictions; Any other relevant information concerning the safety or welfare of the inmate; and transgender or intersex." OCSO policy, Classification, further states, "ICE Detainees will be assigned housing based on the ICE Classification criteria. Detainees are classified by ICE Officials as follows: low, medium low, medium high or high" and "after the initial screening and risk assessment is completed prior to determining each inmates' s primary housing assignment, the inmate shall be placed in a housing area designated for classification purposes. Placement in such housing area shall be temporary pending completion of the classification process, including the determination of appropriate housing, which shall be completed within five (5) business days of each inmate's admission to the facility." During an interview with Classification staff, the Auditor confirmed ICE detainees are housed based on the classification level assigned by ICE. The Classification staff further indicated they can override the classification if the detainee is at risk for suicide or they discover additional criminal convictions that had not previously considered by ICE; however, the results of the initial risk screening are not considered and would not change the detainee classification level assigned by ICE. Classification staff further indicated, detainees will participate in recreation with other detainees housed in the housing unit and that detainees at the facility do not participate in work, volunteer, or other programming. The Auditor reviewed 15 detainee files, none of the files contained documentation to confirm the facility utilized the information received from the risk assessment to determine housing or recreation.

Does Not Meet (a): The facility is not in compliance with subsection (a) of this standard. During an interview with Classification staff, the Auditor confirmed ICE detainees will participate in recreation with other detainees housed in the housing unit; however, they are housed based on the classification level assigned by ICE and not from information received from the risk assessment. Classification staff further indicated detainees do not participate in work, volunteer, or other programming. To become compliant, the facility must develop and implement a procedure to ensure that information received from the risk assessment is utilized when determining a detainees initial housing assignment and recreation. Once implemented, the facility must document training of all applicable staff on the new procedure. In addition, the facility must provide 10 detainee files to confirm information from the risk screening was utilized when initial housing and recreation was determined.

(b)(c): OCSO policy, Classification, states, "Transgender and Intersex inmates will be classified, will be referred to medical, mental health, and the PREA coordinator for review prior to making housing or program assignments." A review of OCSO policy, Classification, confirms it does not contain the requirement that placement and programming assignments of transgender and intersex

detainees will be reassessed at least twice each year to review any threats to safety experienced by the detainee. The Auditor observed the shower areas in the facility. The Auditor reviewed a memo to the file, which states, "Be advised the Orange County Sheriff's Office has not taken any detainees that identify as transgender or intersex into custody during this audit cycle." During interviews with Intake staff, Classification staff and the HSA, the Auditor confirmed medical and mental health staff would be involved in housing a detainee who identifies as transgender/intersex, to ensure his/her health and safety. If the facility were to receive a detainee who identifies as transgender or Intersex, he or she would be housed in a medical cell, until medical staff and mental health personnel could determine the best course of action, that is consistent with the safety and security of the facility and the detainee completes initial classification. Interviews with Intake staff, Classification staff and the HSA could not confirm that placement and programming assignments would be reassessed at least twice each year to review any threats to safety experienced by the detainee. The Auditor observed the shower areas in the facility. All showers are individual showers with individual doors, allowing transgender or intersex detainees an opportunity to shower separately from other detainees. The facility reported there has not been a transgender or intersex detainee, housed at the facility, during the audit period, therefore, the Auditor could not confirm, through a file review that a reassessment is conducted at least twice a year.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. In interviews with Classification staff the Auditor could not confirm that placement and programming assignments of a transgender or intersex detainee would be reassessed at least twice each year to review any threats to safety experienced by the detainee. To become compliant the facility must implement a practice that requires all transgender and intersex detainees' placement and programming assignments be reassessed at least twice each year to review any threats to safety experienced by the detainee. Once implemented the facility must train all classification staff on the updated practice and submit documentation of said training. If applicable, the facility must provide the Auditor with any transgender or intersex detainees who are eligible to be reassessed during the CAP period.

§115.43 - Protective custody.

Outcome: Does Not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): OCSO policy, Protective Custody, Administrative Segregation, states, "Those inmates/detainees that are at a high risk for sexual victimization can only be placed in involuntary segregation if there is no available alternative means of separation from likely abusers. If an assessment for this segregation cannot be done immediately, it must be done in less than 24 hrs. When an inmate/detainee is placed in Involuntary Protective Custody, the Shift Commander will send a report to the Administrator and Captains identifying the inmate/detainee and detailing the reason for the placement. The Administrator will forward copies of the report to the Disciplinary Sergeant who will interview the inmate/detainee and to Classifications. On a weekly basis the Disciplinary Sergeant will review IPC cases. The Disciplinary Wing Sergeant will review all inmates/detainees in Segregation. Sergeants will interview the inmates/detainees and forward review sheets with recommendations to the Security Captain regarding the continuation of protective custody. Review forms will be signed off each week by the Corrections Administrator and the Security or On-Call Captain." OCSO policy, Protective Custody, Administrative Segregation, further states, "Protective Custody inmates/detainees are permitted the same rights as General Population inmates/detainees, with limitations in certain cases. Any limitation will be based on factors specific to the inmate's/detainee's situation, which would place him or her in danger if not restricted." A review of OCSO policy, Protective Custody, Administrative Segregation, confirms it does not require the facility not exceed a period of 30 days when placing a vulnerable detainee in administrative segregation for protective custody. In addition, OCSO policy, Protective Custody, Administrative Segregation, does not require a supervisory staff member conduct a 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, or the requirement to 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 on the basis of a vulnerability to sexual abuse or assault. The Auditor reviewed the Orange County Jail Protective Custody Initial Intake/Weekly Review form. The form indicates who requested protective custody, reason for protective custody, interview finds, and recommendations. During the on-site audit, there were no ICE detainees housed in protective custody. During an interview with the FA, the Auditor confirmed that New York State law prohibits facilities from having an administrative segregation unit in all detention facilities, to include the county jails and the corrections department. If protective custody is needed the detainee is confined to his/her cell to keep the detainee away from other detainees and is afforded at least seven hours outside their cell. If an ICE detainee is placed into protective custody, the ICE Field Office is notified immediately. The detainee has access to programs, visitation, counsel, and other services that are available to the general population. In addition, the Auditor confirmed in an interview with Agency PREA Coordinator, OCSO policy, Protective Custody, Administrative Segregation, has been reviewed and approved by the Agency.

Does Not Meet (b)(d)(e): The facility is not in compliance with subsections (b), (d), and (e) of the standard. A review of OCSO policy, Protective Custody, Administrative Segregation, confirms it does not require the facility not exceed a period of 30 days when placing a vulnerable detainee in administrative segregation for protective custody. In addition, OCSO policy, Protective Custody, Administrative Segregation, does not require a supervisory staff member conduct a 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, or the requirement to 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 on the basis of a vulnerability to sexual abuse or assault. To become compliant the facility must update OCSO policy, Protective Custody, Administrative Segregation to include all elements of the standard. In addition, the facility must refer the updated policy to the Agency for review and approval and submit documented training on all applicable staff on the updated policy. If applicable, the facility must submit to the Auditor any detainee files that include a detainee placed in administrative segregation (protective custody) as a result of being vulnerable to sexual abuse or assault.

§115.51 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "Inmates/detainees shall be encouraged to promptly report signs or incidents of sexual abuse and assault and may not be punished for reporting. Staff shall take seriously all statements from inmates/detainees claiming to be victims of sexual assaults and shall respond supportively and non-judgmentally. Any inmate/detainee may report acts of sexual abuse or assault to any employee, contractor, or volunteer. If an inmate/detainee is not comfortable with making the report to immediate point-of-contact line staff, he/she shall be allowed to make the report to a staff person with whom he/she is comfortable speaking with about the allegations." A review of OCSO policy, SAAPI, confirms it does not contain verbiage that ensures detainees have multiple ways to privately report retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. During the on-site audit, the Auditor observed information on the detainee tablets that advised the detainee's how to contact their consular officials, ORCCC, and the DHS OIG to report an incident of sexual abuse confidentially and anonymously by utilizing the numbers provided. During the on-site audit, the Auditor tested the phone numbers provided, utilizing a detainee tablet and pin. The numbers were in good working order. The Auditor informally interviewed an advocate employed by OCRCC and confirmed the services which are provided to the detainees. In addition, the Auditor attempted to call the DHS OIG. The number rang and it hung up. Interviews with security line staff and supervisors, and the facility PREA Compliance Manager, confirmed detainees at OCCF are provided multiple ways to report sexual abuse, which include telling a staff member, filing a grievance, or reporting to OCRCC.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The facility provides the detainees multiple ways to report sexual abuse; however, a review of OCCF's policy, SAAPI, DHS OIG posters, the facility handbook, and the Intake Orientation form, could not confirm that the facility informs the detainee they can report retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. The Auditor tested the OCRCC number provided on the detainee tablets and confirmed, although the agency would provide a way for the detainee to report an incident of sexual abuse confidentially, the detainee would need to use a pin number to complete the call; and therefore, the call would not be anonymous. The Auditor tested the DHS OIG number provided to the detainees; and confirmed although the line rang it immediately hung up. To become compliant the facility shall develop and implement multiple ways for detainees to anonymously report sexual abuse, retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. Once implemented, information on how to anonymously report an incident of sexual abuse, retaliation for reporting sexual abuse and staff neglect or violations that may have contributed to such incidents shall be disseminated to the ICE detainee population in a manner that all detainees can understand, and documentation of such, shall be forwarded to the Auditor.

§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): OCSO policy, Grievance, states, "An inmate must file a grievance within five (5) days of the act or occurrence giving rise to the grievance. This time frame for filing a grievance does not apply to a grievance filed in regard to sexual abuse." OCSO policy, Grievance, further states, "If the grievance involves sexual abuse or assault, the Grievance Coordinator will immediately notify the Shift Commander and the PREA Coordinator will be notified" and "all grievances will be reviewed by the Shift Commander who will attempt to address any issues which appear to be of an emergency nature." The Grievance policy further states, "whenever an ICE Detainee requests a grievance, the ICE representative will be notified as soon as possible." A review of OCSO policy, Grievance, confirms it contains all steps in which to file an appeal and includes "the chief administrative officer must issue a determination on the grievance appeal within five business days." An interview with the facility GO, confirmed grievances are picked up daily, even on the weekends by the grievance office. If a grievance regarding sexual abuse is received, the GO will ensure the detainee is not in an immediate threat to his health, safety, or welfare, and will immediately forward the grievance to the facility PSA Compliance Manager for investigation. If there is a medical emergency, medical staff would be called immediately for an assessment of the detainee. Once the grievance has been forwarded to the PSA Compliance Manager it is removed from the grievance process, eliminating any time limits imposed by the grievance policy and procedures and any appeal requirements. The GO further indicated that within five days the detainee will be issued a decision that the grievance is being closed and forwarded to the PSA Compliance Manager for an investigation into the allegation. The facility reported there has not been a grievance alleging sexual abuse during the reporting period.

(f): OCCF's facility handbook states, "You may request and will receive assistance in filling out the form." An interview with the GO confirmed a detainee can obtain assistance with preparing a grievance from another detainee, the housing officer or other facility staff, family members, or legal representation. The GO further indicated that the facility would facilitate any requests for assistance, including providing the use of the language line if necessary.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): A review of OCSO policy, SAAPI, confirms it includes outside agencies including MHA, OCRCC, and the NYS Hotline for Sexual Assault and Domestic Violence with contact numbers in their SAAPI protocol. The Auditor reviewed an MOU between MHA, OCRCC, and the OCCF. The MOU lays out the responsibilities of OCRCC, established under the umbrella of MHA, which include providing phone advocacy, responding to calls made by hospital personnel for incarcerated individuals who present in the hospital, provide emotional support and referral information during an investigation, and conduct trainings for law enforcement in regard to

sexual assault services. During the on-site audit, the Auditor observed a flyer, in English and Spanish, on the detainee tablets that includes information about OCRCC, and the services provided. The flyer informs detainees that all services are confidential. The Auditor tested the phone numbers provided, utilizing a detainee tablet and pin. The numbers were in good working order. The Auditor informally interviewed an advocate employed by OCRCC and confirmed the services which are provided to the detainees. The Auditor reviewed the facility handbook and confirmed it advises detainees that phone calls are subject to monitoring. In addition, the Auditor reviewed the Orientation Document that indicated "Information concerning the identity of an inmate-victim reporting a sexual assault or abuse, and the facts of the report itself, shall be limited to those involved in the reporting, investigation, discipline, and treatment process, or as otherwise required by law; however, both pieces of information was not accessible to all detainees in their preferred language. Informal interviews with detainees, indicated they were not aware of the OCRCC, or the services provided, and could not articulate if the calls were confidential, monitored or recorded.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The Auditor reviewed the facility handbook and confirmed that it contains the verbiage, "All phone calls are recorded and may be monitored." In addition, the Auditor reviewed the facility handbook and confirmed it advises detainees that phone calls are subject to monitoring. In addition, the Auditor reviewed the Orientation Document that indicated "Information concerning the identity of an inmate-victim reporting a sexual assault or abuse, and the facts of the report itself, shall be limited to those involved in the reporting, investigation, discipline, and treatment process, or as otherwise required by law; however, both pieces of information were not accessible to all detainees in their preferred language. Informal interviews with detainees, indicated they were not aware of the OCRCC, or the services provided, and could not articulate if the calls were confidential, monitored or recorded. To become compliant the facility must provide detainees with the extent to which reports of abuse will be monitored and forwarded to authorities in accordance with mandatory reporting laws in a manner that all detainees will understand. In addition, the facility must provide the Auditor with documentation that confirms the detainees were provided the information in a manner that all detainees can understand.

§115.54 - Third-party reporting.

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

Notes:

The Auditor reviewed the ICE website, www.ice.gove/prea and OCCF's website https://www.orangecountygov.com/511/Corrections-Jail and confirmed the information regarding third party reporting is posted on both sites. The Auditor tested the contact information for the Orange County Sheriff's Office Corrections Division PREA Coordinator and the contact information for the OCRCC and confirmed both parties would accept reports of sexual abuse on behalf of a detainee.

§115.61 - Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Agency Policy 11062.2, states, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." OCSO policy, SAAPI, states, "Staff shall accept any report made verbally, in writing, anonymously and from third parties. 2) All staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault to the Shift Commander. The Shift Commander shall assure all reports are kept private and only disseminated to on a need-to-know basis to authorized first responders. 3) Staff shall promptly document any allegations reported to them in the form of a report. 4) All cases that appear potentially to support criminal prosecution shall be referred to the Orange County Sheriff's Office Investigations Unit. 5) If the incident involves an ICE detainee, the ICE SAAPI Assessment form will be completed and the Corrections Administrator or designee shall immediately report the incident to the ICE Field Office Director, 6) If an employee, contractor, or volunteer is alleged to be the perpetrator of inmate/detainee sexual abuse or assault, the Corrections Administrator shall also notify the local government entity or contractor that operates the facility. 7) Information concerning the identity of an inmates'/detainees' victim reporting a sexual assault, and the facts of the report itself, shall be limited to those who have a need-to-know in order to make decisions concerning the victim's welfare, and for law enforcement/investigative purposes." A review of OCSO policy, SAAPI, confirms it does not include a method by which staff can report outside the chain of command. The Auditor reviewed the facility staff PREA training curriculum, which states, "Staff will immediately report any allegation received to their supervisor (unless complaint is about their supervisor) or the Shift Commander." Interviews with security line staff and supervisors, indicated staff are aware of the requirement to immediate report a sexual abuse incident and they could report an allegation outside of their chain of command, if necessary. Staff were also aware; that information regarding an incident of sexual abuse is limited to those that need-to-know, to keep the detainee safe, prevent further victimization or to make medical treatment, investigation, law enforcement or other security and management decisions. Security line staff and supervisors did not articulate the need to report any knowledge, suspicion, or information regarding a sexual abuse, the need to report retaliation against a detainee or staff who reported or participated in an investigation about such an incident, or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. During an interview with the PSA Compliance Manager, the Auditor confirmed OCSO policy, SAAPI, was submitted to the Agency for review and approval.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of OCSO policy, SAAPI, confirmed it does not include a method by which staff can report outside the chain of command. In addition, security line staff and supervisors did not articulate the need to report any knowledge, suspicion, or information regarding a sexual abuse, the need to report retaliation against a detainee or staff who reported or participated in an investigator about such an incident, or any staff neglect or violation of

responsibilities that may have contributed to an incident or retaliation. To become compliant, the facility must update OCCF's policy, SAAPI, to include a method by which staff can report outside the chain of command. Once updated, the facility must refer the updated policy to the Agency for review and approval. In addition, the facility must train all staff on the requirement to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred at the facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation and document said training.

(d): OCCF does not house juvenile ICE detainees. During an interview with the PSA Compliance Manager, the Auditor confirmed that New York State does have mandatory reporting laws regarding a vulnerable adult. If an allegation involves a vulnerable ICE detainee a report would be made to the ICE Field Office and the Vulnerable Person' Central Register (VPCR).

Recommendation (d): The Auditor recommends that the facility update OCSO policy, SAAPI, to include reporting an allegation of sexual abuse that includes a vulnerable adult to the ICE Field Office or other ICE personnel.

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

Interviews with Security line staff and supervisors confirmed if they become aware a detainee is at substantial risk of sexual abuse, their first response would be the safety of the detainee and that the course of action would be to seek out the detainee and separate him or her from the detainee population and notify the supervisor. During an interview with the PSA Compliance Manager, it was indicated that the detainee would be separated from the threat and the incident would be referred to an investigator. The Auditor reviewed two sexual abuse investigation files and confirmed that both victims were separated from the abuser and kept safe while facts of the incident were being investigated.

§115.63 - Reporting to other confinement facilities.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c)(d): OCSO policy, SAAPI, states, "Upon receiving an allegation that an inmate/detainee was sexually abused while confined at another facility, the Corrections Administrator shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The Corrections Administrator shall notify the inmates/detainees in advance of such reporting." An interview with the FA confirmed the facility would immediately notify the facility Warden at the facility where the abuse occurred. The notification would initially be made through a phone call and would be followed up with an email. In addition, he would notify the ICE Field Office of the report. The facility Administrator was aware the notification must be made within 72 hours; however, he confirmed he would not wait that long and would immediately notify the facility. If OCCF received such a notification, it would be immediately referred for investigation and notification made to the ICE FOD. The facility provided the Auditor a memorandum regarding an ICE detainee who reported an allegation of sexual abuse that occurred at another facility. The memo is address to the Sheriff of Orange County from a facility investigator. Although the facility notified the ICE FOD, no documentation was provided to indicate that the facility had notified the facility where the incident occurred that they had received an allegation of sexual abuse from their facility.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsection (a) of this standard. The facility provided the Auditor a memorandum regarding an ICE detainee who reported an allegation of sexual abuse that occurred at another facility. The memo is address to the Sheriff of Orange County. No documentation was provided to indicate that the facility, where the incident occurred was notified of the allegation; and therefore, there is no documentation to confirm the provided notification was made to the facility where the allegation took place or that they notification was documented. To become compliant, the facility shall develop and implement procedures to ensure that upon receiving an allegation that a detainee was sexually abused while confined in another facility, the facility shall notify the appropriate office of the agency or the administrator of the facility where the alleged abuse occurred, and forward documentation of such to the Auditor. Once developed the facility must train all applicable staff on the new procedure and submit documentation that confirms the require training was conducted. If applicable, the facility must submit to the Auditor any documents that include any detainees who reported to OCCF during the CAP period of being sexually abused while housed at another facility.

Recommendation (d): The Auditor recommends that the facility update OCCF's SAAPI to include the verbiage, "The agency or facility office that receives such notification, to the extent the facility is covered by this subpart, shall ensure that the allegations are referred for investigation in accordance with this standard and reported to the appropriate ICE FOD."

§115.64 - Responder duties.

Outcome: Does Not Meet Standard. (requires corrective action)

Notes:

(a)(b): OCSO policy, SAAPI, states, "Staff First Responder Duties: 1) Separate the alleged victim and abuser. 2) If staff is alleged to be the sexual abuser, they are to be removed from contact with inmates pending the outcome of the investigation. 3) Preserve and protect any crime scene until appropriate steps can be taken to collect evidence. 4) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take actions that could destroy physical evidence, including as appropriate, washing, washing clothes, brushing teeth, changing clothes, urinating, defecating, drinking, or eating. 5) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including as appropriate, washing, washing clothes, brushing teeth, changing clothes, urinating, defecating, drinking, eating." A review of OCCF's SAAPI confirms it does not include the responsibilities of a non-security first responder during an incident of sexual abuse. In interviews with Security line staff and supervisors, it was confirmed that all the interviewees were knowledgeable in their duties as a first responder, to include if a detainee reported an allegation of sexual abuse to them, they would call for backup, separate the detainee, call for medical, request the detainee victim and ensure the alleged abuser not to take any action that could destroy physical evidence, preserve the crime scene and notify the supervisor. In interviews with a nurse and a mental health provider, each reported they would call for backup, tell them to stop and separate them if they could and notify the supervisor; however, neither non-security first responder indicated that they would request the alleged victim not take any actions that could destroy physical evidence prior to notifying security staff. The Auditor reviewed two reported allegations of detainee-on-detainee of sexual abuse, both cases were reported days later, and therefore, did not include the actions of facility first responders.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. A review of OCSO policy, SAAPI, confirms it does not include the responsibilities of a non-security first responder during an incident of sexual abuse. In addition, neither non-security first responder interviewed, indicated that they would request the alleged victim not take any actions that could destroy physical evidence prior to notifying security staff. To become compliant the facility must update OCSO policy, SAAPI, to include the requirements of non-security first responders. Once updated the facility must refer updated OCSO policy, SAAPI, to the Agency for review and approval. In addition, the facility must train all staff, contractors, and volunteers who have reoccurring contact with detainees on the non-security first responder responsibilities, including requesting the victim not to take any actions that would destroy physical evidence prior to notifying security staff, and document said training.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): OCSO policy, SAAPI, states, "The facility shall incorporate a multidisciplinary team approach to responding to sexual abuse. The Sexual Assault Response Team (SART) shall consist of the PREA Coordinator, contracted medical practitioners, mental health practitioners from the Orange County Office of Mental Health, the Orange County Regional Medical Center Sexual Assault Nurse Examiner, the Protective Custody/Disciplinary Sergeant, and an investigator from the Orange County Sheriff's Office Investigation Unit." The PSA Compliance Manager confirmed OCSO policy, SAAPI, is OCCF's Coordinator Response Plan. In interviews with the PSA Compliance Manager, security line staff and supervisors, medical and mental health staff, and the facility Investigator, it was indicated all staff were knowledgeable and could clearly described their responsibilities when responding to incidents of sexual abuse.

(c)(d): A review of OCSO policy, SAAPI, confirmed the coordinated response plan does not include verbiage for subsections (c) and (d) of the standard, which requires if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "If the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise. During an interview with the FA, he could not articulate what information would be shared stating, "he believed ICE staff and medical staff would be responsible to inform the receiving facility of an incident and the need for medical and social services."

Does Not Meet (c)(d): The facility is not in compliance with subsection (c) and (d) of this standard. A review of OCCF's Coordinated Response Plan confirms it does not include the verbiage for subsections (c) and (d) which require a coordinated plan that includes, (c) if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and (d) if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise. In addition, an interview with the FA could not confirm compliance with subsections (c) and (d). To become compliant, the facility shall revise and update OCCF's Coordinated Response Plan to include the verbiage required by subsections (c) and (d) of the standard. Once updated the facility must provide a copy of OCCF's Coordinated Response Plan to the Auditor to confirm its compliance with subsections (c) and (d0 of the standard. In addition, the facility must train all staff included in the Coordinated Response Plan on the requirements of subsections (c) and (d) of the standard. If applicable, the facility must provide the Auditor with any sexual abuse investigation files, and corresponding medical and mental health records, of a detainee who was transferred due to an incident of sexual abuse to confirm compliance with the standard.

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

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

Notes:

OCSO policy, SAAPI, states, "If staff is alleged to be the sexual abuser, they are to be removed from contact with inmates pending the outcome of the investigation." The policy does not address contractors or volunteers. Despite the lack of policy, during an interview with the FA, the Auditor confirmed that staff would be separated and removed from any contact with detainees, pending the outcome of the investigation. If the allegation is against a contractor or volunteer, they would be removed from the facility and their security clearance revoked pending the outcome of the investigation. There were no allegations of sexual abuse that involved a staff member, contractor, or volunteer reported during the audit period.

Recommendation: The Auditor recommends that OCSO policy, SAAPI, be updated to include the verbiage, "Staff, contractors, or volunteers suspected of perpetuating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation."

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "For at least 90 days following a report of sexual abuse, this agency shall monitor the conduct and treatment of inmates or staff who reported the sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by inmates or staff and shall act promptly to remedy any such retaliation. SRG/CIU member designated to monitor for retaliation shall review inmate disciplinary reports, inmate housing assignments and program changes. For staff, negative performance reviews and post assignments will be monitored. The assigned SRG/CIU member will conduct bi-weekly reviews and document all reviews on the retaliation monitoring form. The retaliation monitoring form will be forwarded to the PREA Coordinator upon completion." In an interview with the RM, the Auditor confirmed detainees who report an allegation of sexual abuse or cooperate with an investigation are monitored for 90 days following the report and that monitoring will continue beyond 90 days if needed; however, the RM could not articulate the need to monitor staff and review post assignments, negative reviews, or reassignments. The Auditor reviewed the facility PREA Retaliation Monitoring Form, which indicates a review of the detainee's disciplinary records, housing, mental health issues, medical issues, and programming. The facility RM reported he will meet with the detainee every two weeks, to ensure there is no retaliation. In addition, he confirmed that there had not been a staff member that required retaliation monitoring during the audit period. The Auditor reviewed two investigations, and confirmed monitoring occurred for the required 90 days in one file. The second file did not contain documentation of retaliation monitoring, as it was determined to be unfounded. There were no detainees who reported an incident of sexual abuse housed at the facility, therefore no interviews were completed.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of this standard. The Auditor reviewed two investigations. Retaliation monitoring could be seen in one of the investigative files; however, monitoring documentation could not be confirmed in the investigation the facility determined to be unfounded. In addition, during an interview with the facility investigator, he could not articulate the need for monitoring a staff member that may report or witness and allegation. To become compliant, the facility shall implement a procedure, to ensure that all detainees and staff who report, witness, or cooperate with an investigation are monitored for up to 90 days or longer if needed. In addition, the facility must train all applicable staff on the new procedure. Once the training is completed, the facility must provide the Auditor with documentation that confirms if was conducted. If applicable, the facility must submit to the Auditor all allegation of sexual abuse investigation files, and the corresponding PREA Retaliation Monitoring form, that occurred during the CAP period.

§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): OCSO policy, SAAPI states, "SART will ensure that the victim is housed in a supportive environment that represents the least restrictive housing option possible, and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted prior to the sexual assault. SART will ensure that the victims are not held longer than five days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim." The Auditor reviewed a memorandum to the file which states, "Be advised the Orange County Sheriff's Office has not utilized any segregated housing to protect any victims of sexual abuse during this audit cycle. During an interview with the facility PSA Compliance Manager, the Auditor confirmed detainees who require protective custody are confined to their cell, while following state statute which allows the detainee to be out of his/her cell for 7 hours a day. If a detainee were placed into protective custody, the detainee would not be removed without the completion of a medical and mental health assessment, which would include the detainee's vulnerability as a result of sexual abuse. In addition, the PSA Compliance Manager, indicated if an ICE detainee is placed into protective custody, the ICE FOD is notified immediately. The Auditor reviewed two investigations; however, protective custody was not utilized in either case. During the on-site audit, the Auditor confirmed there were no ICE detainees being held in protective custody, therefore, no interviews were conducted.

Recommendation (d): The Auditor recommends that the facility update OCSO policy, SAAPI, to include the requirement to notify the appropriate ICE FOD whenever a detainee has been held in administrative segregation for 72 hours.

§115.71 - Criminal and administrative investigations.

Outcome: Does Not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): OCSO policy, SAAPI, states, "A prompt, thorough, objective, and fair investigation shall be conducted into all allegations, including third party and anonymous reports of sexual abuse or assault" and "investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses, and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect or witness shall be assessed on an individual basis and shall not be determined by the person's status as inmate or staff. An inmate that alleges sexual abuse shall not be subjected to a polygraph examination or other truth telling device as a condition for proceeding with the investigation. Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attached copies of all documentary evidence where feasible. Substantiated allegations of conduct that appear to be criminal shall be referred for prosecution. All Administrative investigations shall include an effort to determine whether staff actions or failure to act contributed to the abuse. For all Administrative investigations, this agency shall not impose any standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. All Administrative investigations shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings. The ICE SAAPI Assessment form will be attached to all facility documents." OCCF's policy, SAAPI, further states, "In addition, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling, shall, be maintained in the PREA file." A review of OCSO policy, SAAPI, confirms it does not contain verbiage that requires the facility to retain reports of sexual abuse for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. An interview with a facility Investigator confirmed the facility will conduct an administrative investigation on all allegations of sexual abuse. The investigator will work with the criminal investigators, to ensure that the criminal case is not compromised. In addition, the facility Investigator, the facility PSA Compliance Manager, and the facility Administrator confirmed investigations are prompt, thorough and objective. In an interview with the PSA Compliance Manager, it was indicated that he would notify the ICE FOD if a detainee victim has been held in administrative segregation for 72 hours. The Auditor reviewed two investigations and determined the allegations did not rise to the level that would require a criminal investigation and that all requirements of subsection (c) had been followed.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of OCSO policy, SAAPI, confirms it does not contain verbiage that requires the facility to retain reports of sexual abuse for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. To become compliant the facility must update OCSO policy, SAAPI, to include the verbiage "The facility to retain reports of sexual abuse for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." In addition, the facility must document that all facility Investigators have been trained on updated OCSO policy, SAAPI, and that the updated policy was submitted to the Agency for review and approval.

(e)(f): OCSO policy, SAAPI, states, "The departure of the alleged abuser or victim from employment or incarceration shall not be a basis for terminating an investigation. If such occasion shall arise, that Administration determines that the need for an outside agency investigate alleged abuse, this facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." Interviews with the facility Investigator, the PSA Compliance Manager and the FA confirmed an investigation will continue even if the alleged victim or abuser is no longer housed or employed at the facility. The Auditor reviewed two sexual abuse allegation investigation files that occurred during the audit period and confirmed both detainee victims were housed at the facility through the course of the investigation.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse." OCSO policy, SAAPI, states, "For all Administrative investigations, this agency shall not impose any standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated." An interview with the facility investigator, indicated the facility does not impose a higher standard than a preponderance of evidence in determining whether allegations of sexual abuse are substantiated. An interview with the facility Investigator, it was indicated that allegations of sexual abuse or sexual harassment are substantiated by a preponderance of the evidence as indicated in OCSO policy, SAAPI. The Auditor reviewed two sexual abuse investigation files and confirmed the investigators imposed no standard higher than a preponderance of evidence in determining whether the allegations would be substantiated.

§115.73 - Reporting to detainees.

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

Notes:

Agency Policy 11062.2 states, "For detainees still in ICE immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation of sexual abuse or assault, notify the detainee as to the result of the investigation and any responsive

action taken, in coordination with the FOD." OCSO policy, SAAPI, states, "Following the investigation into an inmate's allegation(s) that he or she suffered sexual abuse in the facility, the Corrections Administrator shall inform the inmate as to whether the allegation(s) has been determined to be substantiated, unsubstantiated or unfounded." The Auditor reviewed the facility Prison Rape Elimination Act of 2003 Post-Investigation Notice to Inmate form and confirmed the form informs the detainee the outcome of the investigation. An interview with a facility Investigator, confirmed the facility notifies the victim of the outcome of the investigation. If they have left the facility, the facility will send the notification to the detainee's last known address on file. The Auditor reviewed two investigations and confirmed the facility Prison Rape Elimination Act of 2003 Post-Investigation Notice to Inmate form had been completed, and the detainees advised of the outcome, in both investigations. During the on-site audit, there were no detainees who reported an allegation housed at the facility, therefore, no interview was conducted.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d): OCSO policy, SAAPI states, "Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse/harassment policy. Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse. Disciplinary sanctions for violations of agency policies relating to sexual abuse or harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. 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 shall be reviewed by Administration to determine if criminal activity has occurred. If so, this incident shall be referred to the proper authorities." Review of OSCO policy, SAAPI, confirms it does not contain the verbiage, "including removal from their federal service for allegations of sexual abuse" and does not indicate "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." However, as termination is greater than removal from Federal Service, the Auditor finds the facility SAAPI in substantial compliance with subsection (b) of the standard. The Auditor reviewed a memorandum to the file, which states, "Be advised the Orange County Sheriff's Office has not sanctioned any staff for sexual abuse during this audit cycle." During an interview with the SDDO/Agency PSA Coordinator, the Auditor confirmed OCSO policy, SAAPI, has been submitted to the Agency for review and approval. An interview with the FA, indicated that staff are subject to disciplinary or adverse actions up to and including removal from their position for substantiated allegations of sexual abuse or for violating Agency or facility sexual abuse policies. In addition, the facility would report any violations of the policies to relevant licensing bodies. The Auditor reviewed two sexual abuse investigation files, although the investigations did not include an allegation of staff-on-detainee sexual abuse, one investigation indicated a staff member had received discipline for violating the facility SAAPI, specifically, failing to report an allegation reported by a detainee; therefore, confirming staff are subject to discipline for violations of the facility policies related to sexual abuse.

§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): OCSO policy, SAAPI, states, "Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse/harassment policy. Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse. Disciplinary sanctions for violations of agency policies relating to sexual abuse or harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed the staff member's disciplinary history and the sanctions imposed for comparable offenses by other staff with similar histories. 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 shall be reviewed by Administration to determine if criminal activity has occurred. If so, this incident shall be referred to the proper authorities." In review of the OCSO policy, SAAPI, confirms it does not include that contractors or volunteers are subject to disciplinary sanctions. During interviews with the FA and the facility PSA Compliance Manager it was indicated that contract staff and volunteers who engaged in sexual abuse would be removed from the facility and reported to law enforcement and relevant licensing bodies. In addition, the FA and PSA Compliance Manager reported there has not been a contractor or volunteer removed from the facility for engaging in or attempting to engage in sexual abuse or in violation of all aspects of the facility policies. Interviews with staff contractors, indicated their awareness that violations of the policy would result in termination. There were no volunteers at the facility during the on-site audit; and therefore, no interviews were conducted.

Recommendation (a)(b)(c): The Auditor recommends that the facility revise OCSO policy, SAAPI, to include verbiage that prohibits contractors and volunteers who engage in sexual abuse contact with detainees pending the outcome of the investigation. In addition, the Auditor recommends that OCSO policy, SAAPI, be updated to include the requirements that the facility take into consideration whether to prohibit volunteers and contractors further contact with detainees who have not engaged in sexual abuse but have violated other provisions within DHS standards and to make reasonable efforts to report incidents of substantiated sexual abuse to relevant licensing bodies and to the local law enforcement unless the activity is clearly not criminal.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f): OCSO policy, SAAPI, states, "Inmates shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the inmate engaged in inmate-on-inmate sexual abuse or following a criminal finding of guilt for inmate-on-inmate sexual abuse. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the inmate's disciplinary history and the sanctions imposed for comparable offenses by other inmates with similar histories. The disciplinary process shall consider whether an inmate's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The agency may discipline an inmate for sexual contact with staff only upon a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." OCSO policy, Disciplinary, states, "Prior to conducting a hearing on an inmate/detainee who has known psychiatric problems, the Hearing Officer will contact the Mental Health unit to discuss the incident. The object of this contact is to determine whether the inmate/detainee's misbehavior was a function of his mental illness rather than intentional misconduct. A disciplinary mental health referral to be completed by Mental Health personnel and shall be included in the hearing packet." OCSO policy, Disciplinary, further states, "Any inmate/detainee engaging in any criminal acts will also be subject to criminal prosecution. Repeated violations of these rules will increase the possible sanctions as determined by the Hearing Officer." Interviews with the FA, PSA Compliance Manager, and facility disciplinary officer confirmed a detainee is subject to disciplinary sanctions and criminal sanctions if warranted. Interviews further indicated that staff were knowledgeable of each element required by the standard to include all levels of review, appeals, the mental health factors, and that detainees cannot be disciplined for sexual contact with staff unless there is a clear showing the staff member did not consent. The facility reported that there have been no detainees subject to disciplinary sanctions as a result of sexual abuse. The Auditor reviewed two investigations of alleged sexual abuse. One investigation was substantiated, and the perpetrator was given a verbal warning after the allegation was determined to be substantiated and a hearing was held. The Auditor confirmed the level of discipline was appropriate for the facts of the allegations. There were no detainees housed at the facility that had reported sexual abuse, therefore, no interview was conducted.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): OCSO policy, Health Services, states, "Inmates/Detainees who have been victims of sexual abuse in any prison, jail, lock up or juvenile facility, are referred urgently to Mental Health for evaluation within 72-hours; if mental health is not available, the inmate is placed in isolation until evaluated." OCSO policy, Health Services, further states, "The Mental Health staff will evaluate any inmate/detainee referred as a sexual assault risk (potential victim or predator). If Mental Health staff determine through their screening process that an inmate/detainee is a sexual assault risk (potential victim or predator, the following actions will be taken: mark the sexual assault risk box in the Offender Management System; inform Classification staff; and schedule a follow-up visit for the inmate/detainee within 14 days (only if inmate/detainee was not determined a risk by any other department). Inmates/Detainees who have been victims of sexual abuse in any prison, jail, lock-up or juvenile facility shall be evaluated and receive appropriate treatment." During an interview with Intake staff, the Auditor confirmed that each detainee is assessed by Intake staff utilizing the facility Sexual Violence/Risk Assessment Screening form. If the detainee score is 4 or higher, the detainee is referred to mental health. Affirmative answers to questions, that require an automatic referral to mental health are scored as a 5, to ensure a referral is completed. Interviews with Intake staff and Classification staff confirmed the scoring process on the assessment and when a referral to medical and mental health is necessary. Interviews with medical staff and mental health staff confirmed the process. In addition, the Auditor confirmed medical staff will complete their own assessment of the detainees during the intake process, if a referral is needed, medical staff will immediately follow up with the detainee or immediately complete a referral for a mental health follow-up. Medical staff indicated that there have been no referrals for medical or mental health, as a result of the risk assessment, during the reporting period. The Auditor reviewed 15 detainee files. No detainees required a medical referral for a medical follow up. There were no detainees who scored high for victimization, however; two detainees scored high for risk of predatory behavior. The files did not contain documentation that a referral had been completed. The Auditor reviewed the mental health file of both detainees. One file indicated that there was a referral completed at intake, the other file did not. The detainee file that had documentation of the referral, came into the facility on October 13, 2021, referral was picked up by mental health staff on October 14, 2021, the detainee was seen on October 26, 2021. The second detainee came into the facility on October 21, 2021, no referral was documented; however, the detainee was seen by mental health staff on and OCCF's October 28, 2021.

Does Not Meet (a)(c): The facility is not in compliance with subsections (a) and (c) of this standard. The Auditor reviewed 15 detainee files and confirmed there were no detainees who scored high for victimization; however, two detainees scored high for risk of predatory behavior. A review of the detainee files did not contain documentation that a referral had been completed; however, the Auditor reviewed the corresponding mental health file of both detainees and confirmed one file indicated that there was a referral completed at intake, the other file did not. The detainee file that had documentation of the referral, came into the facility on October 13, 2021, referral was picked up by mental health staff on October 14, 2021, and the detainee was seen on October 26, 2021. The second detainee came into the facility on October 21, 2021, no referral was documented; however, the detainee was seen by mental health staff but not until October 28, 2021. The Auditor confirmed both detainees who scored high for risk of predatory predator were not seen within the required 72 hours. To become compliant, the facility must ensure that the detainee is referred to a qualified medical or mental health professional if the Sexual Violence/Risk Assessment Screening form indicates a detainee has experienced sexual abuse or perpetrated sexual abuse. In addition, the facility must implement a practice that requires the detainee is seen no later than 72 hours after a referral for a mental health follow-up due to the detainee experiencing prior victimization or perpetrating sexual abuse. The facility must train all intake, medical and mental health staff in the new practice and document such training. In

addition, if applicable, the facility shall forward 10 detainee files that include detainees who scored high for victimization or predatory behaviors.

§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): OCSO policy, SAAPI, states, "Victims shall be provided emergency and ongoing medical and mental health services as needed without financial cost to the inmate, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident" and "pregnancy tests are available to inmate victims of sexually abusive penetration while incarcerated. If pregnancy results from an abusive sexual penetration, the victim shall receive timely and comprehensive information about access to all lawful pregnancy-related medical services. Victims of sexual abuse shall be offered tests for sexually transmitted infections, as medically appropriate." In an interview with the HSA, it was indicated that detainees would receive timely and unimpeded access to emergency medical treatment at the OCRMC and crisis intervention services through the Orange County Office of Mental Health (OCOMH), which includes the OCRCC. In addition, he stated that detainees would be offered timely information and timely access, to emergency contraceptive and sexually transmitted infections prophylaxis, with professional accepted standards of care, where medically appropriate and that treatment is provided to every victim without financial cost, regardless of if the victim names the perpetrator or cooperates with the investigation. During the on-site audit, the Auditor spoke with an advocate of the OCRCC who confirmed that crisis intervention services are provided to victims of sexual abuse at no cost. In addition, the Auditor attempted to contact the SANE Unit at OCMC; however, no one return the Auditor's call. The Auditor reviewed two sexual abuse allegation investigation files that occurred during the audit period and confirmed both detainee victims were seen by medical on the same day the allegation was reported. There were no detainees housed at the facility, that had reported a sexual abuse, and therefore, no interview was conducted.

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

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

Notes:

(a)(b)(c)(d)(e)(f): OCSO policy, SAAPI, states, "Medical and Mental evaluations and treatment is available to all inmates who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Victims shall be provided emergency and ongoing medical and mental health services as needed without financial cost to the inmate, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." OCCSO policy, SAAPI, further states, "Facility Medical Staff and Mental Health staff will provide continuing care as prescribed by the Sexual Assault Nurse Examiner. Pregnancy tests are available to inmate victims of sexually abusive penetration while incarcerated. If pregnancy results from an abusive sexual penetration, the victim shall receive timely and comprehensive information about access to all lawful pregnancy-related medical services. Victims of sexual abuse shall be offered tests for sexually transmitted infections, as medically appropriate." In interviews with the facility HSA, the Auditor confirmed detainees who have been victimized in immigration detention, will receive a medical and mental health evaluation and treatment, which includes pregnancy tests and pregnancy related services, tests for sexually transmitted diseases, follow-up services, treatment plans and referrals for continued care following their transfer to another facility or release from custody. There is no cost to the victim. In addition, the HSA reported medical and mental health care at OCCJ is consistent with the level of care in the community.

(g): OCCF's Classification policy states, "Inmates with a history of sexual predatory behavior are referred to Mental Health, the Shift Commander is to be notified and an alert is placed on the Black Creek system." During an interview with mental health staff, the Auditor confirmed mental health staff will attempt to conduct an evaluation of detainees who have a history of being a sexual predator within 60 days. In addition, the Auditor reviewed the mental health files of two detainees who are known sexual abusers. The files indicated each detainee had been evaluated and received treatment plans within the 60 days. In addition, the Auditor reviewed two investigations of alleged sexual abuse. Both victims were referred to mental health on the same day the allegation was reported.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): OCSO policy, SAAPI states, "1) The facility PREA Coordinator shall, together with the Security Captain, Medical Director, Mental Health Director, and Investigators conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation to assess and improve prevention and response efforts; 2) The review shall occur within thirty (30) days of the conclusion of the investigation; 3) In conducting the review, the PREA Coordinator shall seek input from line supervisors, investigators, and medical or mental health practitioners: 4) The reviewer(s) shall: a. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; b. 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; c. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; d. Assess the adequacy of staffing levels in that area during different shifts; e. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and f. Prepare a report of findings and any recommendations for improvement and submit such report to the facility administrator; g. The facility shall implement the recommendations for improvement or shall documents its reasons for not doing so." During interviews with the FA and PSA Compliance Manager, both confirmed they are members of the review team and that the facility will conduct a review at the conclusion of every investigation of sexual abuse. A written report is prepared within 30

days and recommendations are made if needed. The review team utilizes a template to complete the review. The Auditor reviewed the template and confirmed the form includes names of all staff present at the review; is there a need for a change in policy to better prevent, detect, or respond to sexual abuse; was the incident 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 within the facility; were there any physical barriers with the area the abuse occurred that may have enabled the abuse; is there a need for additional staff, is there a need for additional monitoring technology or augmentation of existing monitoring equipment in the area the abuse occurred, and recommendations as a result of the review. In addition, the Auditor reviewed two investigations in which one was substantiated, and one was unfounded. In both investigations, the Auditor confirmed a review had been completed within 30 days of the conclusion of the investigations and that the Agency PREA Coordinator was included in the review.

(c): OCSO policy, SAAPI, states, "The PREA Coordinator shall review aggregate data on an annual basis and present the findings to the ICE Field Office Director and ICE/ERO headquarters for use in determining whether changes may be needed to existing policies and practices in order to further the goal of eliminating sexual abuse." The Auditor reviewed the OCCF's PREA Coordinator's Annual report for 2020; however, the facility did not provide an annual report for 2022. The 2020 report was addressed to the Orange County Sheriff's Office. An interview with the PSA Compliance Manager indicated the report, or negative report if no allegations of sexual abuse were reported for the year, is forwarded to the Sheriff. The Auditor did not receive documentation that the annual report is forwarded to the FOD or the Agency PSA Coordinator.

Does Not Meet (c): The facility is not in compliance with subsection (c) of this standard. The Auditor reviewed the OCCF's PREA Compliance Manager's Annual report for 2020; however, the facility did not provide a report for 2022. The 2020 report is addressed to the Orange County Sheriff's Office. An interview with the PSA Compliance Manager indicated the report, or negative report if no sexual abuse allegations were reported for the year, is forwarded to the Sheriff. In addition, the Auditor did not receive documentation that the annual report is forwarded to the FOD or the Agency PSA Coordinator. To become compliant, the facility must provide the Auditor documentation that the 2022 annual PREA report, or negative report, has been completed and forwarded to the FOD, or his or her designee, and the Agency PSA Coordinator.

§115.87 - Data collection.

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

Notes:

(a): OCSO policy, Records Retention, states, "Case records, including but not limited to commitment, general information history, presentence investigation reports, record sheets from other agencies, record of personal property taken from prisoner upon commitment, record of letters written and received, copies of general correspondence concerning prisoner, reports of infractions of rules, prisoner's health records, and suicide prevention screening records, but not including commissary records: Retention is 15 years after the death or discharge of prisoner." An interview with the PSA Compliance Manager, indicated that the facility maintains all case records associated with allegations of sexual abuse in a secure area under their control. During the on-site audit, the Auditor observed the storage of records and determined the facility complies with the standard.

§115.201 - Scope of audits.

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

Notes:

(d)(e)(i)(j): During all stages of the audit, including the on-site audit, the Auditor was able to review available policies, memos and other documentation required to make an assessment on PREA Compliance. Interviews with detainees were conducted in private on-site and remained confidential. The Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. No detainee, outside entity, or staff correspondence was received prior to the on-site audit.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	17
Number of standards not met:	22
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.

Robin Bruck 2/26/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 2/26/2023

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 2/28/2023

Assistant Program Manager's Signature & Date