PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	7/19/2022	**To:**	7/21/2022
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	San Diego
Field Office Director:	Jamison Matuszewski
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO)
Field Office HQ physical address:	880 Front Street, San Diego CA, 92101
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:	Otay Mesa Detention Center		
Physical address:	7748 Calzada De La Fuente		
Mailing address: (if different from above)	P.O. Box 438150, San Diego, CA 92143-8150		
Telephone number:	619-671-9724		
Facility type:	CDF		
PREA Incorporation Date:	12/1/2019		
Facility Leadership			
Name of Officer in Charge:	Christopher J. LaRose	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	619-671-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Prevention of Sexual Assault (PSA) Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	619-671-(b) (6), (b)

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Otay Mesa Detention Center (OMDC) was conducted on July 19-21, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt, employed by Creative Corrections, LLC. The Auditor was provided guidance during the audit report writing and review process by the U.S. 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 to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA Standards for the audit period of December 1, 2019, through July 21, 2022. The OMDC is privately owned and operated by CoreCivic and operates under contract with the DHS/ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult male and female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the OMDC are from Russia, Colombia, and Armenia. The facility does not house juveniles or family detainees. This was the first DHS PREA audit for the OMDC and the facility is located in Chula Vista, California.

On July 19, 2022, an entrance briefing was held in the OMDC staffing conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing via telephone and then turned it over to the Auditor. In attendance were:

CoreCivic Staff
Christopher LaRose, Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) PSA Compliance Manager
(b) (6), (b) (7)(C) Quality Assurance Manager
(b) (6), (b) (7)(C) Chief of Security
(b) (6), (b) (7)(C) Health Services Administrator (HSA)
(b) (6), (b) (7)(C) Chief of Unit Management

ICE Staff
(b) (6), (b) (7)(C) Officer in Charge (OIC), ERO
(b) (6), (b) (7)(C) Assistant Field Office Director (AFOD), ERO
(b) (6), (b) (7)(C) OPR/ERAU, Inspections and Compliance Specialist (ICS) (via telephone)

Creative Corrections
(b) (6), (b) (7)(C) - Certified PREA Auditor

The Auditor introduced himself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. Approximately three weeks prior to the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's PAQ, agency policies, and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA is 14-2-DHS, Sexual Abuse and Assault Prevention and Intervention (SAAPI). All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Auditor for the interviews with staff and detainees. The Auditor also reviewed the facility's website, http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews.

On the first day of the audit, there were 838 detainees (778 males and 60 females) housed at OMDC. The current rated capacity for the facility is 1216 males and 142 female adult detainees. Other portions of OMDC house United States Marshals Service (USMS) detainees. There is no comingling of the populations. Both these populations are satellite fed on their respective living units. The ICE detainee in-processing area consists of eight hold rooms. Five of these rooms holds 14 detainees, 1 holds 22 detainees, 1 holds 5 detainees, and 1 holds 4 detainees. All but two of the small rooms have toilets, sitting areas and telephones. Detainees held in the two small rooms are allowed the use of telephones outside of the hold rooms during intake processing. None of the hold rooms have showers. There are three individual showers in the intake area for use if needed. Posters are provided in each of the rooms, consisting of the consulate contact information; the victim advocate, Center for Community Solutions (CCS) contact information; DHS-prescribed ICE Sexual Abuse and Assault Awareness (SAA) information pamphlet and the DHS ICE Zero Tolerance for Sexual Abuse poster with phone and other contact information. The detainees remain in this area until they are individually classified and receive a risk assessment and then are placed in their general population housing. The housing designation at OMDC for males and females changes based on apprehension levels. At the time of the site visit, there were 10 male designated dormitories and 8 female designated dormitories. Besides these dormitory living areas, the facility has 14 housing units (A-P). Each of these units can

accommodate 128 detainees with the exception of C holding 14 high level females and 12 restrictive housing beds for females, D that accommodates 64 restricted housing beds for males and E that can accommodate 64 high security level male detainees. There are nine dormitory beds in medical as well as four single rooms, six negative pressure rooms and one suicide observation room. The break down for the housing units at the time of the audit was two female units and nine male units. During the site visit, the Auditor observed signage requiring opposite gender staff to announce themselves prior to entering each of the living areas. The Auditor also observed female and male staff announcing themselves prior to entering opposite gender living areas during the tour. (b) (7)(E)

OMDC maintains a staff complement of 156 employees, to include security and non-security personnel for the entire detainee and U.S. Marshals complex. According to the PAQ and the interview with the PSA Compliance Manager, there are 362 CoreCivic security staff, 62 Medical Staff, 2 Mental Health Staff, and 11 contractors (Trinity). Volunteers have not been at the facility for over two years. OMDC contracts with Trinity to provide food services to the facility.

At the conclusion of the tour, the Auditor was provided with staff and detainee rosters and randomly selected personnel from each to participate in formal interviews. A total of 29 staff were interviewed, including 12 random staff (line-staff and first-line supervisors) and 17 specialized staff positions. Those specialized staff interviews included 19 questionnaires for the OIC, AFOD, Warden, PSA Compliance Manager, HRM, Learning and Development Manager (LDM), Disciplinary Hearing Officer (DHO), Retaliation Monitor, Incident Review Team member, Intake staff member, Case Manager, Facility investigator, Grievance Coordinator, Trinity staff (2), non-security first responder (2), Medical staff, and Mental Health staff. A total of 34 random detainees (10 females and 24 males) were interviewed. There were 18 detainees interviewed that were limited English proficient (LEP) and required the use of a language interpreter through Language Services Associates (LSA), provided by Creative Corrections. There were two transgender detainees, seven detainees who declared prior victimization, two who had identified as lesbian, gay, or bisexual, and four detainees who filed a sexual abuse allegation interviewed.

There were 15 allegations of sexual abuse reported at OMDC for the audit period. Three were alleged involving staff, all of which were determined unfounded at the completion of the investigation. There were 12 allegations made against other detainees. Of these 12 allegations, 3 were substantiated, 4 were unsubstantiated and 5 were unfounded at the conclusion of the investigation.

On July 21, 2022, an exit briefing was held in the OMDC staffing conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing (via telephone) and then turned it over to the Auditor. In attendance were:

<u>CoreCivic Staff</u>
Christopher LaRose, Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) PSA Compliance Manager
(b) (6), (b) (7)(C) Quality Assurance Manager
(b) (6), (b) (7)(C) Chief of Security
(b) (6), (b) (7)(C) HSA
(b) (6), (b) (7)(C) Facility Investigator
(b) (6), (b) (7)(C) Chief of Unit Management

<u>ICE Staff</u>
(b) (6), (b) (7)(C) OIC, ERO
(b) (6), (b) (7)(C) AFOD, ERO
(b) (6), (b) (7)(C) OPR/ERAU, ICS (via telephone)

<u>Creative Corrections</u>
(b) (6), (b) (7)(C) Certified PREA Auditor

The Auditor spoke briefly about the impressive intake area and the staff and detainee knowledge of the facility 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 he would need to discuss his findings and review interviews conducted (staff and detainee) prior to making a final determination on compliance. The Auditor explained the audit report process time frames and thanked all present for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 3
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.31 Staff training
§115.35 Specialized training: Medical and Mental Health Care

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

Number of Standards Met: 37
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.71 Criminal and 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
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection

Number of Standards Not Met: 0

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 Auditor determined compliance with this subpart of the standard based on review of the 2019 Policy 14-2-DHS mandating, "zero-tolerance towards all forms of sexual abuse." Policy 14-2-DHS details OMDC's approach to establishing this zero-tolerance mandate for staff and detainees. The policy describes hiring practices for employees, contractors, volunteers, and detainees, training requirements for staff and detainees and reporting information based on this zero-tolerance policy. The interview with the PSA Compliance Manager and review of the documentation provided to the Auditor confirmed this policy was reviewed and approved by the agency. The informal and formal interviews with OMDC staff and detainees indicated they were aware of the facility's zero-tolerance policy on sexual abuse.

(d) The Auditor determined compliance with this subpart of the standard based on review of Policy 14-2-DHS that requires, "The facility shall designate a Prevention of Sexual Assault (PSA) Compliance Manager who shall serve as the facility point-of-contact for the local ICE field office and ICE PSA Coordinator." The facility has designated a full time PSA Compliance Manager. During the PSA Compliance Manager's interview, he detailed his responsibilities in this position including being the point of contact for the agency's PSA Coordinator. He confirmed he has sufficient time and authority to oversee efforts for the facility to comply with implementation and adherence to the 14-2-DHS policy. His position is noted on the facility organizational chart as a direct report to the Warden.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of Policy 14-2-DHS that states, "Each facility will ensure sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The CoreCivic Facility Support Center (FSC) will develop, in coordination with the facility, comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and shall review those guidelines at least annually. Each facility will ensure sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating staffing levels and determining the need for video monitoring, the following factors shall be taken into consideration: Generally accepted detention and correctional practices; Any judicial findings of inadequacy; All components of the facility's physical plant; The composition of the detainee population; The prevalence of substantiated and unsubstantiated incidents of sexual abuse; Recommendations of sexual abuse incident review reports; and Any other relevant factors, including but not limited to the length of time detainees spend in agency custody." During the site visit, the Auditor reviewed the staffing guidelines for each shift at OMDC. The Auditor was present on each shift and observed adequate supervision of the detainees as well. The Warden and the PSA Compliance Manager were specifically questioned about detainee supervision at OMDC. The Warden stated that every area where a detainee is present, a staff member is also stationed. (b) (7)(E) [redacted] The Auditor was provided the most recent detainee supervision review for 2021 documenting each of the subpart (c) requirements. This supervision review made no recommendations for changes to either the 14-2-DHS policy or facility operations. The Auditor also reviewed in detail five investigative files for incident reviews. None of the incident reviews cited staffing as a concern or factor in the allegation.

(d) The Auditor determined compliance with this subpart of the standard based on review of Policy 14-2-DHS that requires, "supervisors, shall conduct frequent unannounced facility rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds shall be documented in the applicable log (e.g., Administrative Duty Officer, post log, shift report, etc.). This practice shall be implemented for all shifts and all areas where detainees are permitted. Employees shall be prohibited from alerting other employees that supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the facility." The random staff interviews included each of the three shift supervisors. Each of them confirmed they make at least one round in every location detainees are or have access to, staggering times and locations. During the site visit, the Auditor reviewed random logbooks and found PREA rounds documented by signature on all of the shifts. The security staff, questioned formally and informally, confirmed their awareness of the policy prohibiting them from alerting other staff that supervisors were making rounds.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

OMDC does not accept juveniles or family detainees. The OMDC PAQ confirmed this, as well as interviews with the Warden, PSA Compliance Manager, and personal observations while on-site.

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

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

Notes:

(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on review of Policy 14-2-DHS that requires, "Pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Pat searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All cross-gender frisk/pat searches will be documented in a logbook." While on site the Auditor reviewed the cross-gender pat search log and found no cross-gender pat searches conducted during the audit period. The random male and female staff interviewed confirmed that cross-gender pat searches are not conducted at OMDC except in exigent/emergency situations and in compliance with their training and facility policy.

(e)(f) The Auditor determined compliance with these subparts of the standard based on review of Policy 14-2-DHS that requires, "Strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches shall be documented." The Auditor reviewed the strip search logbook while on site and found no strip searches, to include cross-gender, performed during the audit period. Security staff interviews confirmed their knowledge of the prohibition of strip-searching detainees except in exigent circumstances and the requirement to document per their training and policy requirements. They were also aware that body cavity searches are conducted only by medical staff. Interviews with the Warden, PSA Compliance Manager, and the review of the PAQ confirmed OMDC had no instances of cross-gender strip searches or body cavity searches conducted during the audit period.

(g) The Auditor determined compliance with this subpart of the standard based on review of Policy 14-2-DHS that requires, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Employees of the opposite gender must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." Both male and female detainees are housed at OMDC. During the tour, the Auditor observed signage above each of the housing unit doorway entrances reminding staff to make a cross-gender announcement prior to entering. Also, the Auditor observed during the site visit cross-gender announcements being made prior to the staff entering housing units. The majority of random detainees interviewed confirmed that cross-gender announcements are being made prior to staff entering the living areas. The Auditor reviewed the OMDC camera system views in various areas of the facility. Bathroom and showers areas are not available to camera viewing and the Auditor found no privacy concerns generally or specifically with the shower or toilet areas.

(h) This subsection is non-applicable. OMDC is not a Family Residential Facility.

(i)(j) The Auditor determined compliance with these subparts of the standard based on review of Policy 14-2-DHS that requires, "The facility shall not search or physically examine a detainee for the sole purpose of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. All pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and policy, including officer safety. The gender of the staff member searching a transgender or intersex detainee will depend on the specific needs of the individual detainee and on the operational concerns of the facility. Under most circumstances, this will be a case-by-case determination, which may change over the course of incarceration and should take into consideration the gender expression of the detainee." The Auditor reviewed the OMDC search training curriculum while on site. Security staff receive training consistent with the policy and standard requirements based on this curriculum. Male and female security staff acknowledged the prohibition of searching detainees to determine their genital status and the requirement to perform all pat-down searches in a professional and respectful manner, and in the least intrusive manner as possible. They also informed the Auditor about the procedures for conducting cross-gender and transgender and intersex searches in a professional manner provided in their training. The LDM provided the Auditor with six random security personnel files documenting completed search training in each of their files. The Auditor interviewed two transgender detainees during the site visit. Both indicated they were searched in a respectful and professional manner. Interviews with the other 32 detainees interviewed confirmed that searches conducted at OMDC are accomplished in a professional and respectful manner and voiced no concerns.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. When necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall attempt to accommodate the detainee by

providing: Access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary; Access to written materials related to sexual abuse in formats or through methods that ensure effective communication; and Auxiliary aids such as readers, materials in Braille (if available), audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters, and note-takers. The facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." While the Auditor was conducting his on-site review, there were no detainees going through the intake process. The intake process was detailed to the Auditor by the Senior Detention Officer assigned to the Intake area. He detailed the detainee identification, collection of personal property and the individualized vulnerability assessment and classification each detainee receives upon arrival. According to Senior Detention Officer, the process also requires each detainee be provided an orientation of the agency's and facility's zero-tolerance policy and be provided a copy of the OMDC Facility Handbook, available in Spanish and English, the DHS-prescribed ICE SAA information pamphlet, and the ICE National Detainee Handbook in one of the translated languages. The DHS-prescribed SAA information pamphlet is available in nine languages (English and Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi). The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The Senior Detention Officer further stated that if any of the OMDC staff encounters a detainee who is deaf or limited hearing they would use the TTY to provide information to him or her and indicated that much of the OMDC sexual safety information is available in written format. If a staff member were to encounter a detainee with limited sight, blindness or inability to read or write, then the intake staff would provide audio orientation information, available in Spanish or English, and/or play the sound on the PREA videos. Those detainees not speaking Spanish or English would be provided this information through the contracted interpretive services. The Auditor was also informed that if intake staff encountered a detainee with low intellect, mental health concerns, or limited reading skills then staff would assess the detainee to determine their specific needs and provide information orally or in written format in a manner that ensures their understanding of the material, and if necessary, would require referral to a supervisor, medical, or mental health staff based on the detainee's limitation. LEP detainees, according to the Senior Detention Officer, are dealt with on a daily basis at OMDC and the intake staff utilizes their contracted interpretive language service to assist them with interviews if a staff interpreter is not available. The staff was questioned about providing information to those LEP detainees speaking a language not covered by either the ICE National Detainee Handbook or the DHS-prescribed SAA information pamphlet languages. Staff explained that OMDC utilizes a manuscript that provides information on topics regarding the ICE Detainee Communication, DHS Office of Inspector General (OIG) Hotline, PREA Information, Victim Advocate contact information, and SAAPI information (definitions, prohibitive behaviors and means to report), which is read to the detainee using the interpretive language service. This orientation is documented and acknowledged by signature of the detainee. This process is the same for detainees speaking English, with the exception of the interpreter usage. The Auditor interviewed 34 detainees, and each confirmed this process and confirmed that they received the provided information. The review of 10 detainee files confirmed the signed acknowledgements were present. The Auditor feels the facility exceeds the standard requirements with this process.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." The Auditor questioned staff formally and informally about the 14-2-DHS policy restrictions on the use of interpreters. Of the 15 allegations of sexual abuse reported during the audit period, 9 of the incidents indicated either a staff interpreter or interpreter service was utilized during the investigation. The Investigator indidcated that in each of the nine allegations interpretation services were provided by staff or through their interpretive service and never by another detainee.

§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)(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS, Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive that collectively require, to the extent permitted by law, CoreCivic will decline to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity as outlined above. Policy 14-2-DHS further requires, "all applicants and employees who may have direct contact with detainees shall be asked about previous misconduct, as outlined above in written applications or interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. To the extent permitted by law, CoreCivic may decline to hire or promote and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information." The 14-2-DHS policy and standard subpart (b) require, "all new hires, staff awaiting promotions, and all facility staff on an annual basis to complete and submit a self-declaration form indicating he/she has not engaged in any prohibited conduct. The individual will respond directly to

questions about previous misconduct, as required per the standard and, as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct." 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. The HRM described the hiring protocol at OMDC. All applicants are questioned about any history of sexual assault or abuse during the initial employment process. An affirmative response immediately disqualifies the individual from employment. The HRM further stated all references of prior institutional employment requires each former employer to be contacted about his/her employment history. Any employment information requests from employers about former OMDC employees are responded to once the HRM receives a release of information document signed by the former employee. The hiring process, according to the HRM, includes a thorough ICE background check on the prospective employee. She also stated that the 14-2-DHS policy and the facility practice would be to terminate the employment or withdraw any offer of employment based on material omissions regarding such misconduct outlined in subpart (a) of the standard, or the provision of providing materially false information and any time during the hiring process. She confirmed to the Auditor that every OMDC employee, as a condition of employment, has a continuing affirmative duty to disclose any behavior outlined in subpart (a). The 12 random staff interviewed by the Auditor were aware of this duty to report. Ten employee files were reviewed while onsite and each contained approval to hire from ICE prior to their official start date as well as a signed self-declaration (14-2H-DHS form) that the employee has not engaged in behavior outlined in subpart (a) of the standard and as required by policy to comply with their duty to report. One of the 10 files reviewed was a current promotion with the Auditor observing a current 14-2H-DHS form present in this individual's file as well.

(c)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "Before hiring new employees who may have contact with detainees, each CoreCivic facility shall: Require a criminal records background check. CoreCivic shall further ensure that a criminal record check is completed before enlisting the services of any contractor who may have contact with detainees, CoreCivic shall ensure that criminal background records checks are completed at least every five (5) years for current employees and contractors who may have contact with detainees." The HRM interview confirmed ICE completes background checks for all staff and contractors prior to hiring them and then again, every five years. Review of documentation provided by ICE's PSO confirmed that the 10 employees (7 facility staff to include a contractor and 3 ICE staff) randomly selected for review had background investigations performed prior to hiring. This documentation also confirmed the due dates for the five-year background rechecks. The Auditor determined the provided background investigation information was compliant with the standard requirement.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a)(b) This standard subpart is not applicable as the facility Warden and PAQ confirmed that OMDC only expanded or modified the existing facility within the U.S. Marshals portion of the facility. The facility also did not expand or add additional video equipment during the audit period.

§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) The Auditor determined compliance with this subpart of the standard based on review of Policy 14-2-DHS that requires, "The investigating entity shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developmentally appropriate for youth where applicable, and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic" protocols developed after 2011." Investigation policies and practices for OMDC are outlined in policy 14-2-DHS that was approved by ICE. The OMDC investigator confirmed that his training and protocols maximize obtaining usable evidence in his administrative investigations. The Memorandum of Understanding (MOU) with the San Diego County Sheriff's (SDCS) states the Sheriff will: "Follow a uniform evidence protocol that maximizes the potential for obtaining usable physical eviclence for administrative proceedings and criminal prosecutions; the protocol shall be developmentally appropriate for youth; offer all victims of sexual abuse access to forensic medical examinations, where medically appropriate or necessary to collect evidence. Such examinations shall be performed by a Sexual Assault Forensic Examiner (SAFE) or a Sexual Assault Nurse Examiners (SANE) where possible and as requested by the victim, a victim advocate shall be allowed to accompany and support the victim through the forensic medical exam and investigatory interviews " The agency's Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per Policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO 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 OIG, OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted. There were 15 allegations of sexual abuse reported at OMDC for the audit period. Three were alleged involving staff that were determined unfounded at the completion of the investigation. There were 12 allegations made

against other detainees. Of these 12 allegations, 3 were substantiated, 4 were unsubstantiated and 5 were unfounded at the conclusion of the investigation. The Auditor reviewed five of these allegation investigative files and determined that uniform evidence procedures, to include ensuring detainees do not destroy useable evidence, were followed during the administrative investigations.

(b)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The investigating entity shall attempt to make available to the victim a victim advocate from a rape crisis center. The investigating entity may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services." OMDC has a written MOU with the CCS. The MOU was entered in March of 2021, for 3 years, to provide detainee victims of sexual abuse access to a victim advocate for emotional support services during any forensic examination and any law enforcement interviews. The Auditor reviewed five random investigative files and found notations that indicated detainees were informed of the victim advocate services on the day the allegation was made.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "The investigating entity shall offer all victims of sexual abuse access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners." OMDC has an MOU with Palomar Health that was entered into August 2019, for 10 years to provide forensic examinations for detainee victims of sexual assault, with their consent, by a Forensic Nurse Examiner (FNE). The HSA confirmed all victims of sexual abuse are offered forensic serices at Palomar Health at no cost to the detainee regardless of whether they cooperate with the investigation or not. She also stated the facility had no forensic examinations during the audit period which was further confirmed during the investigative file review.

(e) The Auditor determined compliance with this subpart of the standard based on review of the MOU with the SDCS and interview with the PSA Compliance Manager. The MOU requires OMDC to report all allegation of sexual abuse to their office for criminality review. The MOU further requires, and the SDCS agrees, to comply with all subparts of standard 115.21. This MOU was entered on March 2021 for three years with no sunset date. The Auditor reviewed five investigative files during the site visit. In each of these five investigative files, the Auditor found documentation that the incident was reported to the SDCS.

§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 Auditor determined compliance with these subparts of the standard based on review of Policy 14-2-DHS that requires, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially or criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators. Retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years. When a detainee, of the facility in which an alleged detainee victim is housed, is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center [JIC], the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director/designee. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director/designee, and to any local government entity or contractor that owns or operates the facility." According to information provided to the Auditor, all allegations are to be reported to the JIC, where the allegation will be assessed to determine if it falls within the PREA purview. The PREA allegations are referred to OIG or OPR. DHS OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused by DHS OIG, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for action, and the agency would assign an administrative investigation to be completed. There were 15 allegations of sexual abuse reported at OMDC for the audit period. Three were alleged involving staff that were determined unfounded at the completion of the investigation. There were 12 allegations made against other detainees. Of these 12 allegations, 3 were substantiated, 4 were unsubstantiated and 5 were unfounded at the conclusion of the investigation. The Auditor reviewed five investigative files during the site visit. SDCS was notified in each allegation and an administrative investigation was completed by a trained investigator.

(c) The Auditor determined compliance with this subpart based on the protocols for ICE investigations and CoreCivic investigations being found on their respective web pages: (http://www.ICE.gov/prea) and (http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea).

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all new employees and shall also be included in annual refresher training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards, and shall include: detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, (LGBTI) or gender nonconforming detainees; instruction on reporting knowledge or suspicion of sexual abuse and/or assault; and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and or assault." The SAAPI curriculum and search curriculum was reviewed by the Auditor during the site visit. The SAPPI curriculum provided staff at OMDC details each of the subpart (a) and 14-2-DHS requirements. The LDM confirmed all OMDC staff completed SAAPI training in 2021 and signed the 14-2A-DHS Policy Acknowledgement verification form. The Auditor interviewed 12 random staff and two ICE staff who confirmed they had received PREA pre-service training and receive annual refresher training. Each of their interviews detailed the training content reflected in subpart (a) of the standard. Each of the 10 staff training file reviews found completed 14-2A-DHS documents in each file. Additionally, OMDC subcontracts with Trinity Services Group to provide food services to the detainees. For these subcontractors, the SAAPI curriculum is the same requirement as OMDC staff. Two of these 11 Trinity staff were interviewed, and both detailed the training they received to coincide with the standard and policy requirements. The Auditor reviewed their training records and found the signed 14-2A-DHS Policy Acknowledgement form. The Auditor feels the facility exceeds the standard, as the standard requires refresher training every two years and the facility documentation and interviews confirmed the PREA refresher training is completed annually.

§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) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees shall be notified of the facility's zero-tolerance policy and informed how to report such incidents. Civilians/contractors/volunteers who have contact with detainees on a recurring basis shall be provided a copy of this policy prior to admission to the facility to begin their assignment or task. Civilians/contractors/volunteers shall be required to confirm, by either electronic or manual signature, their understanding of the received training. Signed documentation will be maintained in the civilian or contractor's file." Trinity Services Group is listed as a contractor on the PAQ; however, the Auditor has included them under 115.31 because as subcontractors they have the same access and contact with detainees as OMDC staff. At the time of the audit and since the COVID-19 pandemic, OMDC has no volunteers or other contractors as defined under subpart (d) 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)(e) The Auditor determined compliance with these subparts of the standard based on review of Policy 14-2-DHS that requires, "During the intake process, all detainees shall be notified of the facility's zero tolerance policy on sexual abuse and assault through the orientation program and detainee handbook. Detainees will be provided with information (orally and in writing) about the facility's SAAPI 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 PSA Compliance Manager, and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS /Office of Inspector General (OIG) and the ICE/Office of Professional Responsibility (OPR) investigation processes; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." This process is the same for detainees speaking English, except for the interpreter usage. The Auditor's review of the video transcript, the SAA pamphlet, and the information provided in the ICE National Detainee Handbook confirms that the detainee orientation program notifies and informs detainees about the agency's and facility's zero tolerance policies for all forms of sexual abuse, and is inclusive of all required topics dileneated in provision (a).

As noted in 115.16, the Auditor interviewed the Senior Detention Officer involved with the intake process. He detailed the detainee identification, collection of personal property and the individualized vulnerability assessment and classification each detainee goes through upon arrival. The process also requires each detainee be provided an orientation of the agency's and facility's zero-tolerance policy and be provided the OMDC Facility Handbook in Spanish and English, the DHS-prescribed ICE SAA Awareness Information pamphlet, and the ICE National Detainee Handbook in one of the translated languages. The DHS-prescribed SAA pamphlet is available in nine languages (English and Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. He further stated that if any of the OMDC staff encounters a detainee who is deaf or limited hearing they would use the TTY to provide information to him or her. He also indicated that much of the OMDC sexual safety information is available in written format. If the staff were to encounter a detainee with limited sight, blind or could not read or write then the intake staff would provide audio orientation information available in Spanish or English and/or play the sound on the PREA videos. The Auditor was also informed that if intake staff encountered a detainee with low intellect, mental health concerns, or limited reading skills, then staff would assess the detainee to determine their specific needs and then provide information orally or in written format in a manner that ensures their understanding of the material, and if necessary, would require referral to a supervisor, medical, or mental health staff based on the detainee's limitation. LEP detainees, according to him, are dealt with on a daily basis and the intake staff utilizes their contracted interpretive language service to assist them with interviews if a staff interpreter is not available. The staff was questioned about providing information to those LEP detainees speaking a language not covered by either the ICE National Detainee Handbook or the SAA information pamphlet languages. Staff explained that OMDC utilizes a manuscript that provides information on topics regarding the ICE Detainee Communication, DHS OIG Hotline, PREA Information, Victim Advocate contact information, and SAAPI information (definitions, prohibitive behaviors and means to report), which is read to the detainee using the interpretive language service. This orientation is documented and acknowledged by signature of the detainee. The Auditor interviewed 34 detainees. All but one indicated that they had received orientation materials in a language that they understood. His detention folder was reviewed, and the Auditor found a signed acknowledgement by him that he received the materials in the language indicated he understood. The Auditor's review of 10 detainee files confirmed the signed acknowledgement forms were present. The Auditor feels the facility exceeds the standard requirements with this process.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires the facility to post on all housing unit bulletin boards the following notices: the DHS-prescribed sexual abuse and assault awareness notice; the name of the PSA Compliance Manager, and information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available). During the facility tour, the Auditor observed notices posted with the contact information for the CCC, the DHS ICE Zero Tolerance for Sexual Abuse poster (DHS-prescribed sexual abuse and assault awareness notice as referenced in the policy above) posted with the name of the PSA Compliance Manager, and a copy of the DHS-prescribed SAA information pamphlet. The majority of the 34 random detainee interviews confirmed their knowledge of these posters and the required services available to them.

(f) The facility had ICE National Detainee Handbooks on hand in either printed or PDF format, in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). Based on the Auditor's interviews with the Senior Detention Officer and detainees, and a review of supporting documentation in the detainee files, detainees receive the ICE National Detainee Handbook which contains information about reporting sexual abuse.

§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 Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training covers, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process." The OMDC investigator's training file was reviewed by the Auditor while onsite. It contained his specialized training certificate as well as the training curriculum for investigators provided by CoreCivic. The curriculum addressed the policy and training subpart (a) requirements.

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 Auditor also reviewed the ICE OPR Investigating Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to investigate sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The agency provides rosters of trained investigators and the specialized training curriculum on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirements.

The Auditor did a cursory review of all 15 investigative files and found that each administrative investigation was conducted by the trained OMDC investigator.

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

(a)(b) These subparts of the standard do not apply to OMDC as the facility medical department is operated by CoreCivic employees and not DHS or agency employees.

(c) The Auditor determined compliance with this subpart of the standard based on policy 14-2-DHS that requires, "In addition to the general training provided to all employees, all full and part-time Qualified Health Care Professionals and Qualified Mental Health Professionals, who work in the facility, shall receive specialized medical training as outlined: How to detect and assess signs of sexual abuse; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to victims of sexual abuse; How and to whom to report allegations of sexual abuse; and how to preserve physical evidence of sexual abuse." The OMDC HSA indicated that her staff is prohibited from participating in any evidence gathering or forensic examination in any sexual abuse allegation. She also confirmed that all her medical and mental health staff completed the required PREA and specialized training in 2021. The Auditor randomly chose two medical staff training records and noted the specialized training received as outlined and required in Subpart (b). The Auditor believes the facility exceeds the standard as the standard only requires this specialized training once in a career and OMDC requires it and provides it annually. This Policy, 14-2-DHS, was approved by the AFOD.

§115.41 - Assessment for risk of victimization and abusiveness.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d)(e) The Auditor determined compliance on these subparts of the standard after a review of Policy 14-2-DHS that requires, "All detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within twelve (12) hours of admission to the facility. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: Whether the detainee has a mental, physical, or developmental disability; The age of the detainee; The physical build and appearance of the detainee; Whether the detainee has previously been incarcerated or detained; The nature of the detainee's criminal history; Whether the detainee has any convictions for sex offenses against an adult or child; Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; Whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. The initial screening shall consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive. The facility shall reassess each detainee's risk of victimization or abusiveness between sixty (60) and ninety (90) days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." As noted earlier, the Auditor did not observe the intake process during the site visit. The intake officer detailed the process for the Auditor. After the preliminary intake identification and paperwork is completed, a trained intake Detention Officer (DO) performs the classification and vulnerability assessment. This is typically performed within two hours of the detainee's arrival. The vulnerability assessment is documented on form 14-2B-DHS, Sexual Abuse Screening Tool. This form addresses each of the subpart (c) and (d) requirements. According to the Senior Detention Officer detainees are kept separate from general population during the intake process until the classification process is completed. The Auditor randomly interviewed 34 detainees who confirmed their classification and risk assessments were completed within the first few hours of their arrival at OMDC. The Auditor reviewed 10 detainee detention files during the site visit and found completed 14-2B-DHS forms on the date of the detainee's arrival. Of those 10 files reviewed, 6 detainees were at the facility beyond 90 days. The Auditor found completed reassessments within the required timeframe in each of their detention files. The five investigative case files reviewed confirmed a vulnerability reassessment was completed on each of the detainee alleged victims.

(f) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked about whether the detainee has a mental, physical, or developmental disability; identifies as LGBTI or gender non-conforming; experienced prior sexual victimization or has any concerns about [their] physical safety." The PSA Compliance Manager and Senior DO confirmed detainees are not disciplined for refusing to answer any of the questions asked from the 14-2B-DHS form.

(g) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees." The PSA Compliance Manager and the Senior DO informed the Auditor that completed 14-2B-DHS forms are maintained in the detainee's central file under double lock and restricted key, which was further confirmed by the Auditor during the visit.

§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) The Auditor determined compliance with this subpart of the standard after a review of Policy 14-2-DHS that requires, "The facility shall use the information from the 14-2B-DHS, DHS Sexual Abuse Screening Tool conducted at initial screening in the consideration of

housing, recreation, work program, and other activities." According to the Chief of Unit Management and Case Manager, all detainee assignments for voluntary work and housing are based on each detainee's individualized vulnerability assessment, classification, and any other information available on the detainee. According to these interviews, this is to ensure that any PREA classification, whether it indicates the potential for being at risk of victimization or the potential of being sexual abusive be noted to provide the correct placement. As previously noted, 10 detainee detention files were reviewed, and the Auditor observed the initial assessment and classification documents that demonstrated individualized determinations being conducted to ensure detainee safety.

(b)(c) The Auditor determined compliance with these subparts of the standard after a review of Policy 14-2-DHS that requires, "In deciding whether to house a transgender or intersex detainee in a male housing unit/area or female housing unit/area, or when making other housing and programming assignments for such detainees, the facility shall consider the transgender or intersex detainee's gender self-identification and an assessment of the effect of placement and shall consider on a case-by-case basis whether such a placement would ensure the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions on transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. Placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review whether any threats to safety were experienced by the detainee." Interviews with the HSA and Mental Health practitioner detailed the intake process for transgender and intersex detainees. Transgender or intersex detainees would be seen and evaluated by their respective departments prior to any housing decisions being made. They stated that facility safety and security considerations, as well as the concerns of the detainee, would be considered before placement. The Warden, PSA Compliance Manager, and Classification Manager stated during their interviews that any transgender or intersex detainee would be reassessed every six months and would be allowed to shower separately from other detainees during count times, if necessary, or at times convenient to facility operations. There were two transgender detainees at OMDC at the time of the site visit and the Auditor interviewed both. Both detainees indicated they were placed in the facility medical unit in a private room for one day. They both indicated they were interviewed by a group of four individuals. Two of which they remember as a medical person and someone from mental health. Both these detainees stated they were asked questions about safety concerns they might have and asked which housing environment (male or female) they would feel more comfortable living in. They also both stated that they were provided private shower times.

§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) The Auditor determined compliance with these subparts of the standard after a review of policy 14-2-DHS that requires, "Use of Administrative Segregation to protect detainees at high risk for sexual abuse and assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. Detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director (FOD) to determine if ICE can provide additional assistance. Such detainees may be assigned to Administrative Segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of thirty (30) days. Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If access to programs, privileges, education, or work opportunities is restricted, the facility shall document the reason." The Warden was specifically questioned about the placement of any detainee in segregation to protect him/her from sexual victimization. He confirmed that the use of segregation, for vulnerable detainees at OMDC, would not be his initial response. He stated that his immediate response would be either moving the vulnerable detainee to another housing unit, utilizing one of the facility medical beds, or discussing the situation with the AFOD to expedite a transfer of the detainee. He also stated that segregation has not been utilized for any vulnerable detainee during the audit period. The Auditor interviewed four detainees who alleged sexual abuse during the site visit. Each of them stated that they were never placed in segregation as a result of their vulnerability or allegation.

(d)(e) The Auditor determined compliance with these subparts of the standard after a review of policy 14-2-DHS that requires, "Facilities shall notify the appropriate Field Office Director no later than seventy-two (72) hours after the initial placement into segregation, whenever a detainee has been placed in segregation on the basis of a vulnerability to sexual abuse or assault. If involuntary segregated housing is warranted then the facility will take the following actions: a supervisory staff member shall conduct a review within seventy-two (72) hours of the detainee's placement in segregation to determine whether segregation is still warranted and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in Administrative Segregation and every week thereafter for the first thirty (30) days and every ten (10) days thereafter." According to the Warden, if a detainee were placed in segregation due to the individual's vulnerability, a supervisory review process would be performed as required by policy and the standard. He also stated he would make the placement notification to the FOD within 72 hours.

§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) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall provide instructions on how detainees may contact their consular official, the DHS Office of Inspector General, and the ICE

Hotline. Reporting will be confidential, and if desired, anonymous. Detainees who are victims of sexual abuse have the option to report an incident to a designated employee other than an immediate point-of-contact line officer by using any of the following methods: Submitting a request to meet with Health Services staff and/or reporting to a Health Services staff member during sick call; Calling the facility's twenty-four (24) hour toll-free notification telephone number; Verbally telling any employee, including the facility Chaplain; Forwarding a letter, sealed and marked "confidential", to the Facility Administrator or any other employee; Calling or writing someone outside the facility who can notify facility staff; Contacting the respective consular office; and/or Forwarding a letter to the CoreCivic FSC PREA Coordinator at 10 Burton Hills Boulevard, Nashville, TN 37215. ICE has established the following reporting methods: Directly report to the [DHS OIG] complaint hotline toll-free telephone number at 1-800-323-8603 (this number also has an option to report outside of ICE); Contact the ICE Detention and Reporting Information Line (DRIL) toll-free telephone number 1-888-351-4024 or 9116#; Tell an ICE/ERO staff member who visits the facility; Write a letter reporting the sexual misconduct to the ICE [OIC], ICE AFOD, or ICE FOD using special mail procedures; File a written formal request or emergency grievance to ICE; Contact ICE OPR JIC toll-free hotline number 1-877-246-8253; By mail to DHS OIG, Office of Investigations Hotline; 245 Murray Drive, SW, Building 410/Mail Stop 0305, Washington, DC 20528." As noted in 115.16 and 115.33, during the intake process detainees receive reporting information through the OMDC Facility Handbook, the ICE National Detainee Handbook, the DHS-prescribed SAA information pamphlet and posted signs throughout the facility. Additionally, the DHS OIG and DRIL notices were posted throughout the facility and on the housing units. The 34 random detainee interviews confirmed that each received sexual abuse reporting information upon arrival. Each was also aware of at least one means of reporting a sexual abuse allegation. The 10 detention files reviewed demonstrated signed copies of receipt for these materials. Of the 15 allegations filed during the audit period, 12 were reported through staff, 1 through the telephone and 2 through the grievance office. During the site visit, the Auditor checked the telephone reporting line in three locations. Reporting was available without the use of a PIN.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "Employees must take all allegations of sexual abuse seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports. All reports of sexual abuse will be reported to the Facility investigator. Employees having contact with the alleged victim should behave in a manner that is sensitive, supportive, and non-judgmental." The 12 random security staff interviewed confirmed that they are to accept and immediately report allegations of sexual abuse regardless of how the report was made including anonymous reporting. They were also aware that verbal reports made to them or those from third parties must be documented in writing to their supervisors for investigation. Of the five investigative files reviewed by the Auditor, three were reported to staff. In each of those files the Auditor observed written statements from the First Responder.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after a review of policies 14-2-DHS and 14-5, Inmate/Resident Grievance Procedures, that collectively direct the facility to permit detainees to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. To prepare a grievance a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representative. The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility shall issue a decision on the grievance within 5 days of receipt and shall respond to an appeal of the grievance decision within 30 days. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE FOD at the end of the grievance process." The Grievance Supervisor confirmed that detainees can use the grievance process to make allegations of sexual abuse and that these types of allegations are treated as an emergency grievance with no time limits on when it occurred. She also stated that medical emergencies are referred to the facility medical department immediately. The Grievance Supervisor confirmed upon every allegation of sexual abuse she becomes aware of, she immediately notifies the PSA Compliance Manager, the Warden, and the ICE SDDO. She stated that responses to these type grievances occur within 2 days of receipt and responses to any appeals of the grievance decision are responded to within 30 days. Staff interviews confirmed their awareness that a detainee is allowed to receive assistance from another detainee, the housing officer or other facility staff, family members, or legal representative to prepare a grievance. The facility had two sexual abuse allegations reported through the grievance process during the audit period. Both were responded to within two days and neither response was appealed.

§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) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that states, "CoreCivic shall maintain or attempt to enter into Memorandums of Understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support for immigrant victims of crimes. Each facility shall establish, in writing, procedures to include outside agencies in the facility's sexual abuse prevention and intervention protocols, if such resources are available. Detainees shall be provided access to outside victim advocates for emotional support services related to sexual abuse by giving detainees mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, state, or national victim advocacy or rape crisis organizations. Such information shall be included in the facility's Detainee Handbook. The facility shall enable reasonable communication between detainees and these organizations and agencies, in as confidential a manner as possible. Detainees shall be informed, prior to giving them access, of the extent to which such communications shall be monitored and the extent to which reports on abuse will be

forwarded to authorities in accordance with mandatory reporting laws." The Auditor observed contact information posted in each of the housing units for the CCS in Spanish and English. The CCS accepts allegations of sexual assault if made by a detainee and notifies the facility and local authorities upon receiving the allegation. The OMDC Facility Handbook informs detainees that phone calls to this Center are not monitored. Each of the postings for the CCS in the living areas informs the detainee that the Center is a mandatory reporter. The Auditor's review of five investigative files noted that each alleged victim was provided contact information for the CCS during the initial interview after the allegation was received by the facility. The four detainees interviewed who made allegations of sexual abuse informed the Auditor that each had received information about this community advocate upon making an allegation.

§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 determined compliance with the standard after a review of policy 14-2-DHS that requires, "Each facility shall establish a method to receive third-party reports of sexual abuse and shall post this information on the facility PREA link found on the CoreCivic website." At the entrance to OMDC were notices, in Spanish and English, advising how and to whom to report allegations of sexual abuse on behalf of any detainee. The Auditor also visited the following web sites (https://www.ice.gov) and (http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea), which contain third-party reporting information. The Auditor interviewed 34 detainees during the site visit and most of them were aware that family members and friends could report sexual abuse on their behalf. The facility had one third-party report of sexual abuse during the audit period through the telephone.

§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) The Auditor determined compliance with these subparts of the standard after a review of policy 14-2-DHS that requires, "Employees must take all allegations of sexual abuse seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports. All reports of sexual abuse will be reported to the Facility investigator. Employees having contact with the alleged victim should behave in a manner that is sensitive, supportive, and non-judgmental. All employees are required to immediately report: any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility in accordance with this policy, whether the area is under CoreCivic's management authority; retaliation against detainees or employees who have reported such an incident and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, and as specified in this policy, to make treatment, investigation, and other security and management decisions." The Auditor interviewed 12 security staff and 2 non-security staff while on site about their duty to report allegations of sexual abuse. The security staff were aware of their ability to report outside of their chain of command through the company ethics telephone number. Each was also aware of the requirement to keep all information he/she becomes aware of confidential. As noted earlier, there were 12 allegations made directly to OMDC staff. The five investigative files reviewed noted the staff member responded to the incident in accordance with agency policy and their response training. The 14-2-DHS policy was approved by the AFOD.

(d) The Auditor determined compliance on this subpart of the standard after a review of policy 14-2-DHS that requires, "If the alleged victim is under the age of eighteen (18) or considered a vulnerable adult under a state or local vulnerable person's statute, the allegation shall be reported to the designated state or local services agency under applicable mandatory reporting laws." OMDC only accepts adult male and female detainees, no juveniles. The Warden informed the Auditor that any allegation involving a detainee victim designated as a vulnerable adult would be immediately reported to ICE (AFOD), SDCS and the CoreCivic's legal counsel's office. This office would make the legal notifications as required.

§115.62 – Protection duties.

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

Notes:

The Auditor based compliance on this standard after a review of policy 14-2-DHS that requires, "When it is learned that a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee." The Auditor questioned random staff and security supervisors about the action each would take if they became aware of a detainee who was at substantial risk of sexual abuse. They all confirmed detainee safety would be their primary concern, they would take immediate action to alleviate the risk which would initially require placing him/her in a different location. In each of the five allegations reviewed during the audit period, it appeared staff responded quickly and appropriately to mitigate the threat.

§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) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "If the allegation of sexual abuse involves events that took place while the alleged victim was not in CoreCivic custody (e.g. while housed at another provider's facility, or state, or federal facility), the Facility Administrator of the facility that received the allegation shall ensure that the following actions are taken: Contact the facility head or appropriate office of the facility where the alleged abuse took place as soon as possible, but no later than seventy-two (72) hours after receiving the allegation; Determine from the facility administration at that facility whether the allegation was reported and investigated; If the allegation was reported and investigated by the appropriate officials, the receiving facility shall document the allegation, the name and title of the person contacted, and that the

allegation has already been addressed. Under this circumstance, further investigation and notification need not occur; If the allegation was not reported or not investigated, a copy of the statement of the detainee shall be forwarded to the appropriate official at the location where the incident was reported to have occurred; All such contacts and notifications shall be documented on the 5-1B Notice to Administration; including the allegation, any details learned from contact with the site where the alleged abuse took place, and the facility's response to the allegation and if an allegation is received from another facility, he/she will ensure the allegation is investigated. All allegations of sexual abuse or assault shall be immediately and effectively reported to ICE/Enforcement and Removal Operations (ERO). In turn, ICE/ERO will report the allegation as a significant incident and refer the allegation for investigation." According to the review of the PAQ and interviews with the Warden, PSA Compliance Manager and Facility investigator, the facility received no reports of sexual abuse from any detainee upon arrival at the facility nor was the facility ever contacted by another facility informing them a detainee made an allegation of sexual abuse upon arrival there of an incident occurring at OMDC. According to the Warden, any allegation received from another facility of sexual abuse, that allegedly occurred at OMDC, would be investigated promptly and the AFOD notified. The interview with the OIC and AFOD confirmed that they would make all required notifications to ICE personnel as required by 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) The Auditor determined compliance with this subpart of the standard after a review of policy 14-2-DHS that requires, "Any employee who discovers or learns of sexual abuse, or an allegation of sexual abuse, shall ensure that the following actions are accomplished: the alleged victim is kept safe, has no contact with the alleged perpetrator and is immediately escorted to the Health Services Department; and the Health Services Department is responsible for medical stabilization and assessment of the victim until transported to an outside medical provider, if medically indicated, for collection of evidence and any necessary medical treatment. CoreCivic will request, in writing, that the examination be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE). If a SAFE or SANE provider is not available, the examination may be performed by other qualified medical practitioners. If the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall, to the best of their ability, ensure that the victim does not wash, shower, remove clothing without medical supervision, use the restroom facilities, eat, drink or brush his/her teeth. In order to preserve any evidence, the alleged perpetrator should not be allowed to wash, shower, brush his/her teeth, use the restroom facilities, change clothes, or eat or drink while secured in segregation in a single cell (if available). The highest-ranking authority on-site is immediately notified and will further ensure to protect the safety of the victim and the integrity of the crime scene and any investigation." The Auditor reviewed the SAAPI curriculum that outlines staff responsibilities when responding to allegations of sexual abuse. Twelve random security staff were interviewed and were questioned about their duties when responding to allegations of sexual assault. All of them discussed how they would respond to an allegation covering each of the standards and 14-2-DHS requirements. The five sexual abuse investigative files reviewed by the Auditor appeared to confirm that the first responder followed policy and standard requirements.

(b) The Auditor determined compliance with this subpart of the standard after a review of policy 14-2-DHS that requires, "If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." The Auditor interviewed two non-security staff specifically about their actions in response to a sexual abuse allegation and they both responded they would remove the detainee from the area to a secure location, contact security staff and ensure the detainee does not destroy any potential evidence. There were no allegations of sexual abuse reported to a non-security staff member during the audit period.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "Each facility will establish a Sexual Assault Response Team (SART) which includes the following positions: PSA Compliance Manager; Medical representative; Security representative; Mental Health representative; and Victim Services Coordinator. The SART responsibilities include responding to reported incidents of sexual abuse and assault; responding to victim assessment and support needs; ensuring policy and procedures are enforced to enhance detainee safety; and participating in the development of practices and/or procedures that encourage prevention and intervention of sexual abuse and assault and enhance compliance with DHS PREA Standards." According to the Warden, the entire 14-2-DHS is the coordinated response for sexual allegations occurring at the facility. He confirmed the policy details for each department, the expectations, and procedures to be followed for incidents of sexual abuse. He further stated most of the specific responsibilities are performed by the SART members. A SART member was interviewed by the Auditor during the site visit. He explained his specific responsibilities and how he interacts with the other SART members and departments. The Auditor's review of five investigative files demonstrated the involvement and interactions of medical, mental health practitioners, security staff and the investigator with each incident.

(c)(d) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "If a victim of sexual abuse and assault is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requires otherwise." The Warden, HSA, PSA Compliance Manager and the PAQ confirmed that the facility has had no instances of victim transfers between DHS or facilities not covered by DHS PREA standards

during the audit period. The Warden and HSA further stated that, if they were to transfer a victim of sexual abuse, all proper notifications would be made in accordance with the policy.

§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:

The Auditor determined compliance with this standard after review of policy 14-2-DHS that requires, "Staff suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Contractors and civilians [volunteers] suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation." There were three allegations of sexual abuse against staff during the audit period. In each of the investigative files for those allegations was a notification to: ICE, Shift Supervisor, HRM, and the PSA Compliance Manager indicating the staff member was to be removed from detainee contact until the completion of the investigation. The interview with the Warden also confirmed that staff, contractors, and volunteers suspected of violations of the zero-tolerance policy would be removed from detainee contact pending the results of the investigative process.

§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) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS that requires, "Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least ninety (90) days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond ninety (90) days if the initial monitoring indicates a need to continue. The PSA Compliance Manager shall ensure that thirty/sixty/ninety (30/60/90) day retaliation monitoring is conducted by the designated staff, following a report of sexual abuse, to protect against potential retaliation against detainees or employees. This shall include periodic status checks of detainees and review of relevant documentation. Monitoring is documented on the 14-2D PREA Retaliation Monitoring Report (30/60/90) form. Monitoring shall continue beyond ninety (90) days if the initial monitoring indicates a continuing need." Retaliation monitoring is conducted by the Facility investigator. His interview indicated that when monitoring staff or detainees, the monitoring includes a face-to-face interview with the individual at 30-60-and 90 days. He further stated that in cases where the allegation is substantiated, the detainee abusers are disciplined and moved from the facility. As noted earlier in the report, any staff to alleged to have sexually abused a detainee is automatically removed from detainee contact and in substantiated instances, he/she is terminated. He also confirmed in unsubstantiated allegations, he questions the detainee about any concerns he or she may be experiencing from interactions with that staff member or any staff member. If there are issues, he would monitor these interactions and/or speak to the staff member, as deemed necessary. He also stated that emotional support for any victim of retaliation would be offered, to both staff and detainee. His detainee monitoring processes includes any disciplinary reports issued, housing or program change requests and conversation with the detainee about anything he/she wishes to discuss. His monitoring for staff retaliation includes his review of performance reviews, time off refusals, or reassignment requests. The Auditor reviewed five investigative files while on site and found retaliation monitoring was conducted on each of the detainees alleging sexual abuse. Three were for the complete 90 days, 1 was still being monitored as the 90 days had not expired, and 1 was monitored until the detainee left the facility.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d) The Auditor based compliance on these subparts of the standard after review of Policy 14-2-DHS requiring, "The facility shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. Detainee victims shall not be held for longer than five days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment." As noted in 115.43, the Warden indicated that the placement of any vulnerable detainee in segregation would be his last resort. He also confirmed that would be no different for a victim of sexual abuse. His options for housing would include movement to another housing unit, use of a medical bed or movement from the facility. His interview and the PSA Compliance Manager interview confirmed that during the audit period, segregation was not used to house a detainee victim of sexual abuse. Both also confirmed that if segregation were used as a result of a sexual abuse allegation, the FOD would be notified within 72 hours and a vulnerability assessment would be completed prior to the detainee returning to general population, taking into account the individuals increased vulnerability. The Auditor interviewed four detainees who alleged sexual abuse during the audit period. Each of them stated that they were never placed in segregation for reporting their allegation.

§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) The Auditor based compliance with these subparts of the standard after review of Policy 14-2-DHS requiring, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are

completed for all allegations of sexual abuse. Administrative investigations shall be conducted after consultation with the appropriate investigative office within ICE/OHS, and the assigned criminal investigative entity." According to tFhe interviews with the Warden, PSA Compliance Manager, Facility investigator and the review of the MOU with the SDCS, OMDC is required to report all allegations of sexual abuse to the SDCS for potential criminal action and coordinate the administrative investigation to not interfere with any criminal investigations. The Facility investigator informed the Auditor that his administrative investigations are thorough, prompt and objective and conducted based on his training and OMDC policy requirements. The review of five investigative files found each of the investigations were completed promptly by a trained investigator and appeared to be thorough and objective.

(c)(e)(f) The Auditor based compliance with these subparts of the standard after review of Policy 14-2-DHS requiring, "Administrative investigation procedures include: preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, an witnesses; reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five (5) years; coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." As noted above all allegations are reported to the SDCS. The Facility investigator confirmed that he waits to conduct the administrative investigation after consultation with the appropriate investigative offices within ICE/OPR/DHS and stated he provides assistance where needed during an investigation conducted by any external agency. He detailed his training and responsibilities when conducting his administrative investigations for the Auditor. He stated he relies on direct and circumstantial evidence when available; all physical DNA evidence; electronic monitoring data; interview notes from alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator. The Facility investigator confirmed that the departure of the alleged abuser or detainee victim from the facility or the agency's employment or control would not provide a basis for terminating his investigation. The Auditor reviewed five investigative files during the site visit, and they demonstrated compliance with the subpart (c) and Policy 14-2-DHS protocol requirements.

§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:

The Auditor determined compliance with this standard after review of Policy 14-2-DHS that requires, "In any sexual abuse investigation in which the facility is the primary investigating entity, the facility shall utilize a preponderance of the evidence standard for determining whether sexual abuse has taken place." According to the Facility investigator, his training and the 14-2-DHS policy requires his evidence standard for determining the outcome of a sexual abuse investigation to be the preponderance of evidence. The five investigative files that were reviewed while on site appeared to support the investigator utilized that standard when determining the outcome in these cases.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with this standard after review of Policy 14-2-DHS that requires, "Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken. If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee. All detainee notifications or attempted notifications shall be documented on the 14-2E Detainee Allegation Status Notification. The detainee shall sign the 14-2E Detainee Allegation Status Notification verifying that such notification has been received. The signed 14-2E Detainee Allegation Status Notification shall be filed in the detainee's file." The Auditor interviewed the Facility investigator who confirmed the policy requirement of this detainee notification utilizing the 14-2E form. The Auditor provided the Team Lead with the Notification of PREA Investigation Result to Detainee - ICE Facilities form with five cases that were reviewed at OMDC during the audit period and in all five cases, the detainee was notified of the investigation results.

§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) The Auditor determined compliance with these subparts of the standard after review of Policy 14-2-DHS requiring, "Employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse." According to the Warden, removal from OMDC employment and Federal Service would be the presumptive disciplinary action for any staff member who was found to have engaged in, or attempted to, or threatened to engage in sexual abuse, or failed to follow the zero-tolerance policy. As noted in the standard 115.11 narrative, the 14-2-DHS Policy regarding dismissal from service for violations with the zero-tolerance policy was approved by the AFOD. The facility had three sexual abuse allegations against staff during the audit period, which were all determined to be unfounded after the administrative investigation.

(c)(d) The Auditor determined compliance with these subparts of the standard after review of Policy 14-2-DHS that requires, "All terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal and to any relevant licensing bodies, to the extent known." OMDC reports every allegation of sexual assault to the SDCS. This practice was confirmed by the Warden and OMDC investigator. The Warden also confirmed violations involving anyone with a license would be reported to their respective licensing body as well. There were no substantiated allegations of sexual abuse involving any staff during the audit period.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of Policy 14-2-DHS that requires, "Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall also report such incidents to the FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known. Contractors and civilians suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation." According to the Warden, the 14-2-DHS requires any contractor or volunteer found to have engaged in sexual abuse to be removed from OMDC and be immediately reported to the SDCS. He further stated that anyone with a license found violating the zero-tolerance policy would be reported to their respective licensing body as well. He confirmed he would report any such incident and removal to the AFOD. OMDC has had no such incidents requiring the removal of a contractor or volunteer within the audit period.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of Policy 14-2-DHS and Policy 15-100, Resident Rules and Discipline, that require collectively that detainees be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse, consistent with the requirements of ICE PBNDS 3.1 Disciplinary System. Sanctions are to be commensurate with the nature and circumstances of other abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories, and intended to encourage the detainee to conform with rules and regulations in the future. The disciplinary process shall consider whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. For the purpose of disciplinary action, a report of sexual abuse or assault made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. A detainee shall have the right to due process, which includes the right: to present statements and evidence, including witness testimony on his/her own behalf; and appeal the committee's determination through the detainee grievance process.

The OMDC Disciplinary Hearing Officer (DHO) detailed the detainee disciplinary process for the Auditor. This process allows for progressive levels of reviews, appeals, procedures, and the process is documented as required by the standard and the policy. The DHO further stated that he confers with Mental Health staff prior to conducting a disciplinary hearing on any abuser to determine his/her mental status. There were three detainee-on-detainee substantiated allegations resulting in detainee discipline during the audit period. The Auditor reviewed those cases and the hearing dispositions with the DHO and felt the penalty imposed in each instance aligned with the disciplinary process.

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

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

Notes:

(a)(b)(c) The Auditor determined substantial compliance with these subparts of the standard after review of Policy 14-2-DHS that requires, "If the screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than seventy-two (72) hours after the referral." As noted in 115.41, the initial vulnerability assessment is performed by the intake staff and is entered electronically into the Offender Management System (OMS) and documented on hard copy for the detention file. If a checkmark is entered yes when a detainee is questioned about prior victimization or abusiveness, an email is immediately generated and forwarded to medical and mental health for follow up. The HSA confirmed this victim and abuser notification process during her interview. She also confirmed that the follow up meeting to a yes notation of victimization or prior abusiveness would typically be no later than 24 hours for medical follow up and 72 hours for mental health follow up. The Auditor reviewed five detainee medical files who disclosed prior victimization upon arrival, and they were seen by medical staff on the day that they disclosed the prior victimization. When the Auditor spoke with the Mental Health Practitioner, he was told detainees with prior victimization are prioritized for a meeting depending on when the prior victimization occurred in his/her life, as deemed appropriate during the initial evaluation by the medical staff.

§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) The Auditor determined compliance with these subparts of the standard after review of Policy 14-2-DHS and Policy 13-79 (Sexual Assault Response) that collectively require "detainee victims of sexual abuse and assault be provided timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." Policy 13-79 states, "The nature and scope [of care] are determined by QHCP [Qualified Health Care Professional] and/or QMHP [Qualified Mental Health Practitioner] according to their professional judgment." As noted in standard 115.35, the OMDC HSA indicated that her staff is prohibited from participating in any evidence gathering or forensic examination in any sexual abuse allegation. She also confirmed that any alleged victim of sexual assault would receive emergency medical treatment, crisis intervention services, and emergency contraception including sexually transmitted infections prophylaxis performed within professionally accepted standards of care and without cost. The HSA also stated that no detainees were sent out for a forensic examination during the audit period. The Auditor interviewed four detainees, while on site, who made allegations of sexual abuse. Each confirmed that they were immediately taken to the medical unit upon informing staff of the allegation. The review of the five investigative files and the associated medical files confirmed detainees were provided immediate medical staff and mental health services at the time the facility became aware of the allegation.

§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) The Auditor determined compliance with these subparts of the standard after review of Policy 14-2-DHS that requires, "The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. The facility shall provide victims with medical and mental health services consistent with the community level of care. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services." Policy 14-2-DHS and Policy 13-79 require the evaluation and treatment of such victims to include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Policy 13-79 states, "Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The HSA confirmed every detainee alleging sexual abuse is seen by medical and if necessary, transferred to the outside hospital for a forensic examination. She also described the care each detainee would receive as a result of the allegation to include: services consistent with the community-level of care or better; without any cost to the detainee, regardless of whether he/she cooperates with the investigation arising from the incident and on-site crisis intervention services, sexually transmitted infections treatments and other infectious diseases testing along with prophylactic treatment to victims and pregnancy testing and service if necessary. The Auditor interviewed four detainees who made allegations of sexual abuse within the audit period. Each confirmed that they were immediately taken to the medical unit upon informing staff of the allegation. Two continue to receive crisis intervention services. The Auditor's review of the five investigative files and the associated medical files confirmed detainees were provided immediate medical staff and mental health services at the time the facility became aware of the allegation.

(g) The Auditor determined compliance with this subpart of the standard after review of Policy 14-2-DHS that requires, "The facility shall attempt to conduct a mental health evaluation of all known Detainee-on-Detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." Policy 13-79 requires, "QMHP shall attempt to conduct a mental health evaluation of all known detainee on detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate. If the detainee refuses a mental health evaluation, the refusal will be documented on the 13-49B Refusal to Accept Medical Treatment form and placed in the medical record." The Mental Health Practitioner confirmed that all known abusers as well as detainees found to have perpetrated sexual abuse at the conclusion of an investigation would be offered an evaluation and follow up treatment. There were three substantiated allegations of sexual abuse at OMDC during the audit period. Each of the three detainees, found to have abused other detainees, were referred to and seen by the mental health practitioner.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b) Policy 14-2-DHS requires, "the Facility Administrator to ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation. In addition to the Facility Administrator, the incident review team shall include upper-level facility management and the facility SART, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; and examine the area in the facility where

the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. All findings and recommendations for improvement will be documented on the 14-2F-DHS Sexual Abuse Incident Review Report. Completed 14-2F-DHS forms will be forwarded to the Facility Administrator, the PSA Compliance Manager, and the [CoreCivic] FSC PREA Coordinator. The facility shall implement the recommendations for improvement or shall document reasons for not doing so. The 14-2F-DHS Sexual Abuse Incident Review Report or shall be forwarded to the [CoreCivic] FSC PREA Coordinator and the ICE Prevention of Sexual Assault (PSA) Coordinator through the local ICE Field Office." Interview the Warden and PSA Compliance Manager self-disclosed that during the facility's pre-audit they were made aware that they were required to conduct incident reviews on all closed allegations and they had only been completing reviews on substantiated and unsubstantiated. The facility immediately implemented corrective action and completed incident reviews on the unfounded cases to date prior to the audit. Additionally, a member of the Incident Review Team was interviewed who further confirmed that since their pre-audit, the facility is now conducting an incident review on every investigation within 30 days of conclusion regardless of the disposition. In each of the five randomly chosen investigative files, the Auditor observed a review completed and documented within the 30-day window. The Incident Review Team member also stated that copies of the reviews are distributed to all parties as required by policy and the standard. There were no recommendations made by the committee as a result of their review. The Auditor has found the facility substantially compliant although the facility was not conducting reviews on unfounded cases prior to their pre-audit visit. This assessment was based on their response to implement immediate corrective action once the deficiency was identified. Additionally, the incident reviews reviewed by the Auditor that were completed prior to the pre-audit and within the audit period were found to all be completed according to the requirements of the standard. Interviews with the Warden, PSA Compliance Manager, and the Incident Review Team member, confirmed the corrective action is well established.

(c) The Auditor determined compliance with this subpart of the standard after review of Policy 14-2-DHS that requires, "Each facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the Facility Administrator, FSC PSA Coordinator, and the ICE PSA Coordinator through the local ICE Field Office." The Auditor was provided the facility annual review of sexual abuse allegations and subsequent incident reviews for 2021, dated March 15, 2022. The PSA Compliance Manager confirmed a copy of this review is provided to the FOD and the agency PSA Compliance Manager.

§115.87 - Data collection.

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

Notes:

(a) The Auditor determined compliance on this subpart of the standard after review of Policy 14-2-DHS that requires, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be retained in accordance with Core Civic Policy 1-15 Retention of Records." The Auditor was shown the location, file room in the intake area, where these documents are stored at OMDC and found them under a double lock and restricted key to only those staff with a need to know.

§115.201 - Scope of audits.

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

Notes:

(d) The Auditor was allowed access to OMDC and able to revisit areas of the facility as needed during the site visit.
(e) The Auditor was provided with and allowed to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j) The Auditor observed audit notices posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor received no staff or detainee, or other party correspondence.

AUDITOR CERTIFICATION

Update Audit Findings Outcome Counts by Clicking Button:

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	3
Number of standards met:	37
Number of standards not met:	0
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 9/13/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/13/2022

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/13/2022

Assistant Program Manager's Signature & Date