PREA Audit: Subpart B
DHS Holding Facilities
Corrective Action Plan Final Determination

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Marlean Ames	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	El Paso Field Office		
ICE Field Office Director:	Kenneth Genalo		
PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	11541 Montana Ave Suite E, El Paso, Texas 79936		
Mailing address: *(if different from above)*			
INFORMATION ABOUT FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Pecos Hold Room		
Physical address:	260 E. Palmer St., Pecos Texas 79772		
Mailing address: *(if different from above)*	P.O. Box 470, Pecos, Texas 79772		
Telephone number:	432-445-8300		
Facility type:	ICE Staging Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Assistant Field Office Director (AFOD)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	432-681-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	432-448-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found Pecos Hold Room (PHR) met 23 standards, had 0 standards that exceeded, had 1 standard that was non-applicable, and had 6 non-compliant standards. As a result of the facility being out of compliance with six standards, the facility entered into a 180-day corrective action period which began on October 7, 2022, and ended on March 21, 2023. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance. Due to unforeseen circumstances, the CAP was reviewed, and final determination was completed by (b) (6), (b) (7)(C) Assistant Program Manager (APM), who is a Department of Homeland Security (DHS) and Department of Justice (DOJ) certified Auditor, employed by Creative Corrections, LLC.

Number of Standards Initially Not Met: 6

§115.113 Detainee supervision and monitoring
§115.117 Hiring and promotion decisions
§115.121 Evidence protocols and forensic medical examinations
§115.161 Staff reporting duties
§115.165 Coordinated response
§115.182 Access to emergency medical services

The facility submitted documentation, through the Agency, for the CAP on October 20, 2022, through March 13, 2023. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on March 13,2023. In a review of the submitted documentation, to demonstrate compliance with the deficient standards, the Auditor determined compliance with all six of the standards. At the conclusion of the CAP period, the Auditor determined PHR achieved full compliance with the DHS PREA Standards.

Number of Standards Met: 6

§115.113 Detainee supervision and monitoring
§115.117 Hiring and promotion decisions
§115.121 Evidence protocols and forensic medical examinations
§115.161 Staff reporting duties
§115.165 Coordinated response
§115.182 Access to emergency medical services

Number of Standards Not Met: 0

Facility Risk Rating

§115.193 – Low Risk

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence replied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit.

§115. 113 - 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 PHR provided a written directive, Policy 11087.1 which addresses the requirements of the standard. Policy 11087.1 states, "The Field Office Director (FOD) shall ensure that each holding facility maintains sufficient supervision of detainees, including through appropriate staffing levels, and where applicable, video monitoring, to protect detainees against sexual abuse and assault. In so doing the FOD shall take into consideration a) The physical layout of each holding facility; b) The composition of the detainee population; c) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; d) The findings and recommendations of the sexual abuse review reports; e) Any other relevant factors, including the length of time detainees spend in custody." The SDDO provided a duty roster of all ICE staff for each shift. The roster showed adequate staffing to ensure proper supervision of detainees to ensure their safety and security. Staff members conduct regular and scheduled detainee hold room checks which are recorded in logbooks. During the tour, the Auditor noted that the holding rooms are checked every 15 minutes to ensure all areas are safe and secure. Holding room doors always remain open when not occupied by a detainee to maintain better visibility. (b) (7)(E) [redacted] This practice was confirmed during interviews with both the PSA Compliance Manager and DOs. Post orders are in the administrative desk area in the intake processing room for easy review. The Auditor observed staff signatures on post orders which indicated they have read and understood the documents.

The facility submitted the HFSAT dated April 30, 2022. This process is completed annually, and the document's purpose states, "It is used to determine if the facility maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse." The Auditor reviewed the document and confirmed that the document does not include information regarding the development and documentation of comprehensive detainee supervision guidelines to determine and meet each facility's detainee supervision needs, nor does it confirm that the supervision guidelines were reviewed during the year 2021, or 2022 as required by subsection (b) of the standard. In addition, although in an interview with PSA Compliance Manager, he indicated that the facility took into consideration, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated an unsubstantiated incident of sexual abuse, the findings and 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, a review of the HFSAT did not confirm that the facility took into consideration the required elements of the standard when determining adequate supervision or the need for video monitoring.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. The facility did not provide documentation for the year 2021, or 2022 regarding the annual review of the supervision guidelines; and therefore, the Auditor could not confirm that the annual review of the supervision guidelines was completed as required by the standard. In addition, the facility did not provide documentation that the facility took into consideration: the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated an unsubstantiated incident of sexual abuse, the findings and 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 when determining adequate supervision or the need for video monitoring. To become compliant, the facility must provide documentation that the annual review of the supervision guidelines was completed for the year 2021 or 2022. In addition, the facility must provide documentation that the facility took into consideration: the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in agency custody when determining adequate supervision or the need for video monitoring.

Corrective Action Taken (b)(c): The facility submitted a memo from the Assistant Field Office Director (AFOD) that confirms the Immigration and Customs Enforcement (ICE) Field Office Director (FOD) conducted an annual review of ICE Directive 11087.1 for 2023 on March 6, 2023, concluding that the requirement of the supervision guidelines that staff conduct 15-minute hold room checks is still applicable to the PHR. In addition, the facility submitted a copy of the HFSAT that confirms that whenever a detainee is housed in the holding rooms staff is staged in the area to provide direct supervision of the detainee (s). Based on the submitted HFSAT, that confirms staff are always staged in the holding areas when a detainee is housed there, the Auditor accepts that the Agency took into consideration all elements of subsection (c) of the standard when determining that direct supervision of detainees housed in the hold room is required. Upon review of the submitted documentation the Auditor now finds the facility in compliance with subsections (b) and (c) of the standard.

§115. 117 - Hiring and promotion decisions

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

Notes:

(a)(b)(c)(d)(e)(f): 5 CFR 731, Executive Order 10450, ICE Directive 6-7.0, ICE Personnel Program Security and Suitability, and ICE Directive 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel, require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." In addition, 5 CFR 731 requires investigations every five years. The PSA Compliance Manager confirmed during an interview that background checks are performed for all new hires and internal promotions. The policy outlines misconduct and criminal misconduct as grounds for unsuitability including material omissions or making false or misleading statements in the application. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Based on information provided in an email by the OPR PSO (A) Division Chief, information on substantiated allegations of sexual abuse involving a former employee would be provided to prospective employers upon request, unless prohibited by law. As confirmed during an interview with the SDDO, all staff have a continuing affirmative duty to disclose any misconduct as required by the standard and material omissions regarding such misconduct, or the provision of materially false information, would be grounds for termination.

The Auditor created a random list of five ICE DOs working at the PHR and submitted them to the ICE PSO. The Auditor received a written response regarding up-to-date background checks on the five ICE DOs on July 26, 2022. In addition, the APM created a random list of four contract transportation employees and submitted the list to the ICE PSO. The APM received a written response from the ICE PSO that stated, "Our system did not locate records for the names provided." Therefore, the Auditor could not confirm that the contract transportation employees received a background check prior to being hired as required in subsection (d) of the standard. As confirmed during the interview with the SDDO, all staff considered for a promotion shall be asked during the promotion application process, to disclose any previous misconduct, have an updated background investigation and impose a continuing affirmative duty to disclose any such misconduct. The one current SDDO was recently promoted and confirmed this process was followed.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The APM created a random list of four contract transportation employees and submitted the list to the ICE PSO. The APM received a written response from the ICE PSO that stated, "Our system did not locate records for the names provided." Therefore, the Auditor could not confirm that the contract transportation employees received a background check prior to being hired. To become compliant, the facility must submit documentation that all contract transportation employees received a background check prior to being hired.

Corrective Action Taken (d): The facility provided an email from West Texas Detention Facility Human Recourses confirming that criminal background checks were completed on both the facility and corporate level for LaSalle Transportation staff. Upon review of the submitted documentation the Auditor now finds the facility is in compliance with subsection (d) of the standard.

§115. 121 - 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:

(b)(c)(d): The PHR provided policy 11087.1, which states in part that "The FOD shall coordinate with the ERO HQ, and the Agency PSA Coordinator, in utilizing, to the extent available and appropriate, community resources and services that provide expertise and support in areas of crisis intervention and counseling to address victims' needs." Policy 11087.1 further states that "where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the FOD shall arrange or refer an alleged victim detainee to a medical facility to undergo a forensic medical examination, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFE's or SANE's cannot be made available, the examination can be performed by other qualified health care personnel. If in connection with an allegation of sexual abuse, the detainee is transported for a forensic examination to an outside hospital that offers victim advocacy services, the detainee shall be permitted to use such services to the extent available consistent with security needs." The Auditor confirmed through interviews with the PSA Compliance Manager that there are no local rape crisis services provided to a detainee for advocacy services during a forensic medical examination (FME), investigative interview emotional support, or any follow-up referrals resulting from a sexual abuse allegation, or did the facility provide documentation of an attempt to enter into an agreement with an available community resource. In addition, the Auditor contacted RAINN who indicated that they do not provide hospital advocacy. Therefore, the facility is not in compliance with subsections (b) and (d) of the standard. In an interview with the SDDO, he indicated that all services will be provided only with the detainee's consent and at no cost regardless of if the victim names the abuser or cooperates with the investigation; however, the facility did not provide any documentation to confirm that Reeves County Hospital would provide services only if the detainee consents and at no cost

regardless of if the victim names the abuser or cooperates with the investigation offer. In addition, the Auditor reviewed a memorandum from the AFOD that states, "In coordination with the investigative agency, Pecos, Texas medical services are to be called to administer medical care for the victim to include transport to the local hospital to initiate any Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examination (SAFE) test on the subject." In an interview with the PSA Compliance Manager, it was indicated that a victim of sexual abuse would be taken to the Reeves County Hospital for an FME; however, the facility did not provide any documentation to confirm that Reeves County Hospital would offer an FME or a SAFE/SANE examiner. Therefore, the Auditor could not confirm compliance with subsection (c) of the standard. The Auditor called Reeves County Hospital and spoke to a staff person requesting general information. However, the staff person could not confirm services would be provided to detainees for a FME by a SAFE/SANE or advocacy services provided should the detainee consent and at no cost to the detainee.

Does Not Meet (b)(c)(d): The facility is not compliant with subsections (b), (c), and (d) of the standard. Interviews with the PSA Compliance Manager, and SDDO, could not confirm that Reeves County Hospital would offer emergency treatment, if evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent. In addition, the Auditor, could not confirm during interviews with the PSA Compliance Manager and SDDO that a forensic exam would be conducted by a SAFE or SANE where practicable, or, if SAFE's or SANE's cannot be made available, the examination would be performed by other qualified health care personnel. In an interview with the PSA Coordinator, it was confirmed that the facility did not utilize any available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling, nor did it confirm the use of a victim advocate during the forensic exam should one be requested by the detainee victim. In addition, the Auditor contacted RAINN, via telephone, and was advised that they do not offer hospital advocacy. To become compliant, the facility must enter, or attempt to enter, into an agreement with a local hospital to provide the detainee victim a forensic exam, if evidentiarily or medically appropriate, by a SAFE/SANE Nurse or other qualified medical practitioner. In addition, the facility must enter, or attempt to enter, into an agreement with a community resource to provide expertise and support in the areas of crisis intervention and counseling and to provide advocacy services, if not available through the hospital agreement, to the detainee victim during a forensic exam and during the investigation process. The facility must provide documented training to all applicable regarding the agreements entered and their responsibility to provide the detainee victim with all requirements of the standard. The facility must also provide the Auditor, if available, any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (b), (c), and (d) of the standard.

Corrective Action Taken (b)(c)(d): The facility provided an email from The Crisis Center of West Texas confirming that they would provide SANE services to any person needing such services at the request of law enforcement. In addition, the email confirmed that the center would also provide victims of sexual abuse advocacy services as required by the standard. Upon review of the submitted documentation the Auditor now finds the facility in compliance with subsections (b), (c), and (d) of the standard.

(e): The facility provided no documentation to confirm that PHR made a request to the PTPD to request they follow the requirements of paragraphs (a) through (d) of the standard when investigating allegations of sexual abuse. In addition, in an interview with the SDDO, the Auditor could not confirm that the PTPD would follow the requirements of paragraphs (a) through (d) of the standard when investigating allegations of sexual abuse.

Does Not Meet (e): The facility is not compliant with subsection (e) of the standard. The facility did not provide documentation that the PTPD was contacted to request they follow the requirements of subsections (a) through (d) of the standard. To become compliant, the facility must request that the PTPD follow the requirements of paragraphs (a) through (d) of the standard when investigating allegations of sexual abuse.

Corrective Action Taken (e): The facility submitted an email correspondence with the Pecos Texas Police Department (PTPD) requesting they comply with subsections (a) through (d) of the standard. Upon review of the submitted documentation the Auditor now finds the facility in compliance with subsection (e) of the standard.

§115. 161 - Staff reporting duties

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

Notes:

(d): Policy 11062.2, states in part; "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of the Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." Interviews with ICE DOs indicated that all reported allegations involving a vulnerable adult would immediately be reported to the SDDO on duty who would in turn immediately report the allegation to the OIG; however, they did not confirm that they would coordinate with the OPLA OCC or report the incident to any local authority having oversight as necessary under applicable mandatory reporting laws, as required by policy 11062.2. Interviews with ICE DOs and SDDO further confirmed the facility did not house juveniles. There were no allegations of sexual abuse reported at the PHR during the extended audit period.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. Interviews with ICE DOs indicated that all reported allegations involving a vulnerable adult would immediately be reported to the SDDO on duty who would in turn immediately report the allegation to the OIG; however, they did not confirm that they would coordinate the OPLA OCC or report the incident to any local authority having oversight as necessary under applicable mandatory reporting laws, as required by policy 11062.2. To become compliant, the facility must train all applicable staff on the requirements of policy 11062.2 which state they implement a practice that "If alleged victim under the age of 18 or determined, after consultation with the relevant OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section" and document said training. In addition, the facility must provide the Auditor, if applicable, all allegations of sexual abuse investigative files involving a vulnerable adult that occur during the Corrective Action Period (CAP) period.

Corrective Action Taken (d): The facility provided documented training of all applicable staff, dated 12/13 – 12/14/2022, that included a reminder that all applicable staff, pursuant to 11062.2, in consultation with OPLA OCC, are required to report and document allegations of abuse to the designated state or local services under applicable mandatory reporting laws. In addition, the facility provided a memo to the Auditor confirming that there were no allegations of sexual abuse reported at PHR during the CAP period. Upon review of the submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

§115. 165 - Coordinated response

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

Notes:

(b)(c): Policy 11087.1, requires "If a victim is transferred from a holding facility to a detention facility or to a non-ICE facility, the FOD shall inform the receiving facility of the indecent and the victim's potential need for medical or mental health care of victim services." The PSA Compliance Manager indicated during interviews that if a detainee being transferred was a victim of sexual abuse, the PHR staff would provide the receiving facility any information regarding the sexual abuse allegation, including the victim's need for any medical or social services follow-up; however his interview could not confirm that should the detainee be transferred to a facility not covered by paragraph (b) of the standard that the facility will take into consideration the detainee's request not to have his/her potential need for medical or social services shared with the receiving facility. There were zero allegations of sexual abuse reported at the PHR during the extended audit period.

Does Not Meet (c): Policy 11087.1, as it relates to standard 115.165 is not consistent with the standard. The policy as it relates to the coordinated response protocol does not include "unless the victim requests otherwise." Although the other Agency directive, 11062.2, is compliant with the DHS PREA Standards, if hold rooms are using 11087.1 as their coordinated response protocol, or even a combination of both, then they would be deficient. To become compliant, the Agency must update their written institutional plan to contain the required verbiage as written in 115.165 subpart (c). The facility must provide documented training of applicable staff on the updated written institutional plan. In addition, the facility must provide the Auditor with any investigation, medical, and detainee files regarding any detainee victim of sexual abuse transferred during the CAP period.

Corrective Action Taken (c): The facility submitted an Agency bulletin entitled "Application of DHS PREA 115.165: Coordinated Response" which updates Policy 11087.1 to include the required verbiage of subsections (c) and (d) of the standard. In addition, the facility provided documentation that all applicable staff have been trained on 11087.1 which included the Agency bulletin. The facility submitted a memo to the Auditor that confirms that PHR has not had any reported allegations of sexual abuse during the CAP period. Upon review of the submitted documentation the Auditor now finds the facility is in substantial compliance with subsection (c) of the standard.

§115. 182 - Access to emergency medical services

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

Notes:

(a)(b): The PHR provided a written directive, Policy 11087.1, which addresses the requirements of the standard and states in part; "The FOD shall ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The FOD shall coordinate with ERO HQ, and the Agency PSA Coordinator, in utilizing, to the extent available, any community resources and services that provide expertise and support in the areas of crisis intervention and counseling to address the victims' needs." Policy 11087.1 further provides that "victims of sexual abuse shall be provided emergency medical and mental health services and any ongoing care necessary. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost regardless of whether the victim names the abuse or cooperates with any investigation arising out of the incident." The interview with the PSA Compliance Manager confirmed that a detainee alleging sexual abuse and in need of emergency care would be taken to the Reeves County Hospital; however, the facility did not provide any documentation to confirm that Reeves County Hospital would ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually

transmitted infections prophylaxis, in accordance with professionally accepted standards of care or that the treatment services, both emergency and ongoing, will be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor called Reeves County Hospital and spoke to a staff person requesting general information. However, the staff person could not confirm services would be provided to detainees for a FME by a SAFE/SANE or advocacy services provided should the detainee consent and at no cost to the detainee. Therefore, the Auditor could not confirm compliance with subsections (a) and (b) of the standard. There have been no allegations of sexual abuse during the extended audit period.

Does Not Meet (a)(b): The facility is not compliant with subsections (a) and (b) of the standard. The interview with the PSA Compliance Manager, confirmed that a detainee alleging sexual abuse and in need of emergency care would be taken to Reeves County Hospital, however, the facility did not provide any documentation that the hospital would ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care or that the treatment services, both emergency and ongoing, will be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. To become compliant the facility must enter, or attempt to enter, an agreement with a local hospital to provide detainee victims of sexual abuse or assault with timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and that the treatment services, both emergency and ongoing, will be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. In addition, the facility must provide the Auditor, if applicable, with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (a) and (b) of the standard.

Corrective Action Taken (a)(b): The facility submitted email correspondence with Reeves County Hospital District requesting an agreement to provide detainee victims of sexual abuse or assault with timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and that the treatment services, both emergency and ongoing, will be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. In addition, the facility provided a memo to the Auditor which confirms there were no reported allegations of sexual abuse during the CAP period. Upon review of the submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

§115.193
Outcome: Low Risk
Notes:

The PREA Audit at the PHR was the second audit for this facility. Following the CAP, the Auditor finds the facility meets all six previously non-compliant standards; and therefore, is in compliance with DHS PREA Standards. Therefore, the Auditor has determined that the facility is low risk.

AUDITOR CERTIFICATION:

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

Sabina Kaplan April 5, 2023
Auditor's Signature & Date

(b) (6), (b) (7)(C) April 5, 2023
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) April 6, 2023
Program Manager's Signature & Date

PREA Audit: Subpart B
DHS Holding & Staging Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	7/26/2022	**To:**	7/27/2022
AUDITOR INFORMATION			
Name of auditor:	Marlean Ames	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	330-327-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	722-579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	El Paso Field Office		
Field Office Director:	Kenneth Genalo		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	11541 Montana Ave Suite E, El Paso, Texas 79936		
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:	Pecos Hold Room		
Physical address:	260 E. Palmer St., Pecos Texas 79772		
Mailing address: (if different from above)	P.O. Box 470, Pecos, Texas 79772		
Telephone number:	432-445-8300		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Assistant Field Office Director (AFOD)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	432-681-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer (SDDO)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	432-448-(b) (6), (b)
ICE HQ USE ONLY			
Form Key:	29		
Revision Date:	12/14/2021		
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 Pecos Hold Room (PHR) was conducted July 26 and 27, 2022. The audit was conducted by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Marlean Ames, employed by Creative Corrections, LLC. The Auditor was provided guidance and review 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 (b) (6), (b) (7)(C) Assistant Program Manager (APM), 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. This was the second PREA audit for the PHR and included a review of the audit period from September 1, 2017, through July 27, 2022. As there were zero allegations of sexual abuse reported at the PHR for the prior 12-month period, the audit period was extended to capture closed investigations that occurred since the facility's last audit; however, there were none.

The PHR is a holding facility that processes detainees within 12 hours and is operated by DHS ICE. The PHR is located at 250 E. Palmer St. Pecos, Texas, 79772. Approximately, two weeks prior to the on-site audit the ERAU Team Lead, (b) (6), (b) (7)(C) provided the completed Pre-Audit Questionnaire (PAQ) along with supporting documents and policies for the PHR on the secure ERAU SharePoint website. The provided information included Agency policies, training records and curricula, facility schematics, and a multitude of other related documentation and materials to determine compliance with the DHS PREA standards. The Auditor completed the review of all the documentation that was provided by the Team Lead, and the PHR, in the FY22 Facility Document folder found on the SharePoint platform. The main policies that provide facility direction is Agency policy 11062.2, Sexual Abuse and Assault Prevention and Intervention (SAAPI), and Agency policy 11087.1, Operations of ERO Holding Facilities. The Auditor also reviewed the Agency's website, https://www.ice.gov. The intent of the documentation is to support how a facility establishes a baseline for its actual practice for zero-tolerance for sexual abuse and sexual harassment. The Auditor did not identify any gaps or issues that needed follow up during the initial review.

On July 26, 2022, at approximately 8:00 am, the Auditor met with facility administration in the conference room where the entry briefing was moderated by the Team Lead via teleconference. In attendance at the briefing, either in person, or via teleconference were the following:

(b) (6), (b) (7)(C) ICE/OPR/ERAU, Inspections and Compliance Specialist (ICS)
(b) (6), (b) (7)(C) ICE/OPR/ERAU, ICS (via telephone)
(b) (6), (b) (7)(C) ICE/ERO, AFOD
(b) (6), (b) (7)(C) ICE/ERO, SDDO
(b) (6), (b) (7)(C) ICE/ERO, SDDO
Marlean Ames, Certified DOJ/DHS Auditor, Creative Corrections, LLC.

The meeting was designed to create a positive working relationship, place names with faces, and prepare for the next two days. Soon after the conclusion of the meeting, the Auditor began the facility tour with the AFOD, and both SDDOs. The holding room facility is a single floor, free standing building with a gated sally-port for vehicles to enter to the rear of the building where detainees are received. The PHR has four hold rooms with a total design capacity of 44. Detainees enter the facility through the rear door in a secure vestibule area where they receive a pat-down search prior to entering the hold rooms. Detainees are placed in hold rooms based upon their determined classification for safety and security of both the detainee and staff. During the onsite tour, the Auditor observed that detainees are offered the ICE National Detainee Handbook and the DHS-prescribed Sexual Assault Awareness Information pamphlet in their preferred language.

Detainees are held for approximately four hours for processing purposes at the PHR and are not housed overnight. According to facility staff, the facility receives both male and female detainees from local facilities and prepares them for deportation. The PHR does not process any juveniles through the facility. The PHR operates during the hours of 0600 – 1400 Monday through Friday, which includes completing the intake process. All PHR processing staff are ICE Deportation Officers (DOs). According to the PAQ, and Holding Facility Self-Assessment Tool (HFSAT), the facility employs La Salle contract staff to provide transportation of the detainees. During the last 12 months there were 998 adult detainees: 0 transgender, 0 juveniles and 0 intersex, processed through the PHR. The facility did not break down the 998 adult detainees into male and female population on the PAQ.

During the tour, the Auditor looked for possible blind spots, camera placement, and the detainee-to-officer ratio in accordance with the holding room capacity for occupancy. There were no blind spots observed or identified during the facility tour. Onsite, there is a total of nine sworn officers, one sworn facility management staff, and two sworn supervisory personnel that may have contact with detainees. There are eight male DOs and one female DO to support the necessary staff-to-detainee ratio. The Auditor looked at privacy issues, how the toilet areas were configured, and if detainees have adequate privacy to perform bodily functions. The Auditor

observed that DHS Zero-Tolerance PREA posters, in both English and Spanish, were displayed in the holding areas and in the public areas as well. PREA audit notices, sent to the PHR prior to the on-site visit, were observed posted in all holding areas as well as throughout the facility. The notices provide information on how detainees, and/or staff, could contact the Auditor should they have any concerns prior to the on-site visit. No correspondence was received from detainees, staff, or other individuals during the audit phase.

During the tour, the Auditor noted that there were no phones in the holding rooms. A private room with a telephone for any detainees wishing to make a call was observed. Detainees can request to make private telephone calls during the intake process. The room contained poster information on how to contact the ICE Detention Reporting and Information Line (DRIL) and the DHS Office of Inspector General (OIG) by using specific number keys to complete a call in their preferred language. The private room also contained the DHS Zero-Tolerance PREA posters, in both English and Spanish, and the PREA audit notice. Information containing the Rape, Abuse and Incest National Network (RAINN) was also available to detainees should they wish to call. The Auditor called the RAINN hotline number to confirm advocacy services would be provided to a detainee. No code was needed for the RAINN hotline, allowing for anonymity. The call was received by a live person in which it was explained that a PREA audit was being conducted. The advocate indicated they would speak with a detainee to provide confidential emotional support, self-care tools, and referrals, if requested, but would not accept an allegation of sexual abuse. The phone call confirmed that the private interview room telephone used for detainee reporting of sexual abuse allegations provided a direct line for anonymous calls and was in working order.

The detainee population at the PHR is always fluid, as detainees may be arriving and departing throughout various times of the day. Due to the short stay, there are no rooms with beds or showers. Detainees remain in the clothing they arrive in and are offered sweatpants or sweatshirts for temperature comfort if needed. There are no educational rooms, library, on-site medical clinic, food service or recreation areas located at the PHR. The Auditor observed during the tour that there was sufficient staff to ensure a safe environment for both detainees and staff. During the tour, the Auditor conducted informal conversations with staff regarding duties, responsibilities, and DHS PREA standards. The Auditor also conducted a total of 25 formal interviews utilizing 9 staff. The staff interviewed included five DOs, two SDDOs, one AFOD and the Prevention of Sexual Assault (PSA) Compliance Manager. The interviews covered detainee supervision and monitoring, detainee reporting of sexual abuse, first responders' duties to sexual abuse allegations, viewing and searching detainees by staff of the opposite gender, detainee risk assessment, what the facility's training responsibilities entail regarding contract staff, providing information regarding zero-tolerance policy to detainees, and protecting detainees from contact with alleged abusers. In addition, the interview with the PSA Compliance Manager covered referrals of sexual abuse allegations for investigations, upgrades to the holding facility and technology, receiving allegations from and reporting allegations to other facilities, coordinating with outside investigations, designee on access to emergency medical services for detainee victims of sexual abuse, sexual abuse allegations, incident reports and processing, and volunteer training on sexual abuse should there be any volunteers brought into the facility in the future. Due to their transport assignment, there were zero La Salle contract staff available to interview. All staff interviewed were aware of the Agency's zero-tolerance policy, their responsibilities to protect detainees from sexual abuse, and their first responder duties as part of the coordinated response. Interviewed staff were randomly selected by the Auditor, using the daily duty roster, provided by the SDDO. The Auditor chose staff with different levels of experience. The ICE DOs interviewed by the Auditor demonstrated an understanding of PREA and their responsibilities under their specialized duties. There was a total of 30 male detainees that arrived at PHR during the onsite audit. Due to COVID restrictions, the Auditor was not able to interview any detainees as they were held in congregate quarantine.

A review of the PREA allegation spreadsheet confirmed there were no sexual abuse allegations reported at the PHR during the extended audit period.

On Wednesday, July 27, 2022, an exit briefing was held at approximately 12:00 pm in the conference room to discuss the audit findings. The ERAU ICS Team Lead opened the meeting, via telephonic conference line, and then turned it over to the Auditor for an overview of findings. In attendance at the exit meeting were:

(b) (6), (b) (7)(C) ICE/OPR/ERAU, ICS
(b) (6), (b) (7)(C) ICE/OPR/ERAU, ICS (via telephone)
(b) (6), (b) (7)(C) ICE/ERO, AFOD (via telephone)
(b) (6), (b) (7)(C) ICE/ERO, SDDO
Marlean Ames, Certified DOJ/DHS Auditor, Creative Corrections, LLC.

The Auditor thanked everyone and extended appreciation to the entire staff at the PHR for their cooperation, professionalism, and hospitality during the audit. The Auditor spoke briefly regarding the staff's knowledge on ICE Policy 11062.2. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit, and that she would need to review all submitted documentation and notes from interviews conducted with staff. The Auditor explained the audit report process, timeframes, 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: 0

Number of Standards Not Applicable: 1
§115.114 Juveniles and family detainees

Number of Standards Met: 23
§115.111 Zero-tolerance of sexual abuse
§115.115 Limits to cross-gender viewing and searches
§115.116 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.118 Upgrades to facilities and technologies
§115.122 Policies to ensure investigation of allegations and appropriate agency oversight
§115.131 Employee, contractor, and volunteer training
§115.132 Notification to detainees of the agency's zero-tolerance policy
§115.134 Specialized training: Investigations
§115.141 Assessment for risk of victimization and abusiveness
§115.151 Detainee reporting
§115.154 Third-party reporting
§115.162 Protection duties
§115.163 Reporting to other confinement facilities
§115.164 Responder duties
§115.166 Protection of detainees from contact with alleged abusers
§115.167 Agency protection against retaliation
§115.171 Criminal and administrative investigations.
§115.172 Evidentiary standard for administrative investigations
§115.176 Disciplinary sanctions for staff
§115.177 Corrective action for contractors and volunteers
§115.186 Sexual abuse incident reviews
§115.187 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 6
§115.113 Detainee supervision and monitoring
§115.117 Hiring and promotion decisions
§115.121 Evidence protocols and forensic medical examinations
§115.161 Staff reporting duties
§115.165 Coordinated response
§115.182 Access to emergency medical services

Holding Facility Risk Rating:
§115.193 Audits of standards – **Not Low Risk**

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.

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

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

Notes:

(a): The PHR provided a written directive Policy 11062.2, which addresses the requirements of the standard. Policy 11062.2 mandates, "ICE has a zero-tolerance policy for all forms of sexual abuse or assault. It is ICE policy to provide effective safeguards against sexual abuse and assault of all individuals in ICE custody, including with respect to screening, staff training, detainee education, response and intervention, medical and mental health care, reporting, investigation, and monitoring and oversight." During the interview with the PSA Compliance Manager, he discussed Policy 11062.2 and stressed the importance of sexual safety for detainees. All ICE staff formally interviewed reported they were aware of the zero-tolerance policy and confirmed the requirements are discussed on a regular basis during team meetings. In addition, the Auditor conducted informal conversations with the ICE DOs during the facility tour, who further confirmed that the PHR has a zero-tolerance for all forms of sexual abuse and assault. Due to their transport assignment, there were zero La Salle contract staff available to interview; however, the training curriculum provided, and the training acknowledgement signed by contract transportation staff, confirmed their knowledge in the Agency's zero-tolerance policy.

§115.113 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): The PHR provided a written directive, Policy 11087.1 which addresses the requirements of the standard. Policy 11087.1 states, "The Field Office Director (FOD) shall ensure that each holding facility maintains sufficient supervision of detainees, including through appropriate staffing levels, and where applicable, video monitoring, to protect detainees against sexual abuse and assault. In so doing the FOD shall take into consideration a) The physical layout of each holding facility; b) The composition of the detainee population; c) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; d) The findings and recommendations of the sexual abuse review reports; e) Any other relevant factors, including the length of time detainees spend in custody." The SDDO provided a duty roster of all ICE staff for each shift. The roster showed adequate staffing to ensure proper supervision of detainees to ensure their safety and security. Staff members conduct regular and scheduled detainee hold room checks which are recorded in logbooks. During the tour, the Auditor noted that the holding rooms are checked every 15 minutes to ensure all areas are safe and secure. Holding room doors always remain open when not occupied by a detainee to maintain better visibility. (b) (7)(E) [redacted] This practice was confirmed during interviews with both the PSA Compliance Manager and DOs. Post orders are in the administrative desk area in the intake processing room for easy review. The Auditor observed staff signatures on post orders which indicated they have read and understood the documents.

The facility submitted the HFSAT dated April 30, 2022. This process is completed annually, and the document's purpose states, "It is used to determine if the facility maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse." The Auditor reviewed the document and confirmed that the document does not include information regarding the development and documentation of comprehensive detainee supervision guidelines to determine and meet each facility's detainee supervision needs, nor does it confirm that the supervision guidelines were reviewed during the year 2021, or 2022 as required by subsection (b) of the standard. In addition, although in an interview with PSA Compliance Manager, he indicated that the facility took into consideration, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated an unsubstantiated incident of sexual abuse, the findings and 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, a review of the HFSAT did not confirm that the facility took into consideration the required elements of the standard when determining adequate supervision or the need for video monitoring.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of the standard. The facility did not provide documentation for the year 2021, or 2022 regarding the annual review of the supervision guidelines; and therefore, the Auditor could not confirm that the annual review of the supervision guidelines was completed as required by the standard. In addition, the facility did not provide documentation that the facility took into consideration: the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated an unsubstantiated incident of sexual abuse, the findings and 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 when determining adequate supervision or the need for video monitoring. To become compliant, the facility must provide documentation that the annual review of the supervision guidelines was completed for the year 2021 or 2022. In addition, the facility must provide documentation that the facility took into consideration: the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and

recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in agency custody when determining adequate supervision or the need for video monitoring.

§115.114 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): The PHR does not hold juveniles and family detainees. This was confirmed during interviews with the SDDO, PSA Compliance Manager, and ICE DOs. According to the PAQ, there have not been any juveniles booked into the PHR for any purpose during the audit period. Per interview with PSA Compliance Manager, any juvenile that would falsely represent their identity as an adult would be moved to a facility which exclusively serves juveniles.

§115.115 - 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)(e)(f): Policy 11087.1 states, "The FOD shall ensure that when pat down searches indicate the need for a more thorough search, an extended search (i.e., strip search), is conducted in accordance with ICE policies, including that a) All strip searches and visual body cavity searches are documented; b) Cross-gender strip searches or cross gender visual body cavity searches are not conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners; and c) Visual body cavity searches of minors are conducted by a medical practitioner and not by law enforcement personnel." Policy 11087.1 further states, "The FOD shall ensure that ERO personnel do not search or physically examine a detainee for the sole purpose of determining the detainee's gender. If the detainee's gender is unknown, it may be determined during conversation, reviewing medical records, or learning that information as part of a broader medical examination conducted in private by a medical practitioner." The PSA Compliance Manager reported that there had not been any cross-gender visual body cavity searches or strip searches conducted during the audit period. Interviews with ICE DOs indicated that any strip search or body cavity search would be the result of an exigent circumstance that would involve the notification to an SDDO and the generation of an incident report. In addition, interviews with ICE DOs indicated that pat-down searches are not conducted for the sole purpose of determining the genital status of any detainee. Interviews with ICE DOs further indicated that the facility is pre-notified regarding the detainee intake for the day and therefore, the facility is prepared to have the one female ICE DO onsite to conduct pat down searches should they be receiving female detainees. Staff interviews and the existence of detainee search log documents confirmed that searches would be documented. The Auditor reviewed ICE DO training records and confirmed ICE DO staff are trained in the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees. In addition, the Auditor was able to observe two male detainee pat-down searches conducted by two male ICE DOs. ICE DO interviews confirmed that pat down search training was conducted during their original in-person orientation training when hired. Per interview with the SDDO, contract transportation staff do not perform detainee pat down searches.

(d): Agency Policy 11087.1 addresses the requirements of the provision and states in part that "the FOD shall ensure that detainees are permitted 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 hold room checks, a medical exam, or monitored bowel movement under medical supervision. The FOD will also ensure that ERO personnel of the opposite gender announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." It was confirmed through direct observation that detainees can perform bodily functions without being observed by staff. The Auditor observed, during the tour, that the bathroom toilets were covered with half walls to ensure privacy. (b) (7)(E) [redacted] The Auditor further confirmed that detainees are not permitted to shower or change clothing while housed at PHR due to their short stay while being processed. The use of cross-gender announcements prior to entry into holding areas was confirmed through interviews with ICE DOs indicating they are aware of, and adhere to, the announcement procedure. During the onsite visit, the Auditor observed male detainees in hold rooms; however, there were no female DOs on duty to allow for direct observation of cross-gender announcements.

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

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

Notes:

(a)(b)(c): The PHR provided a written policy 11087.1, which addresses the requirements of the standard. Policy 11087.1 states, "The FOD shall take appropriate steps to ensure that detainees with disabilities have an equal opportunity to participate in, and benefit from, processes and procedures in connection with placement in an ERO holding facility, consistent with established statuary, regulatory, DHS and ICE policy requirements. The FOD shall take reasonable steps to ensure meaningful access to detainees who are limited English proficient, consistent with established regulatory and DHS/ICE policy requirements." The facility also provided policy 11062.2 which states, "Appropriate steps in accordance with applicable law to ensure that detainees with disabilities (including detainees who are deaf or hard of hearing, those who are blind, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in, and benefit from, all aspects of agency and facility efforts to prevent, detect, and respond to sexual abuse. In matters related to allegations of sexual abuse or assault, ensure the provision of in-person or telephonic interpretation that enable effective, accurate, and impartial interpretation by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is

appropriate and consistent with DHS Policy." The PHR takes appropriate measures to ensure detainees with disabilities and detainees who are limited English proficient (LEP) have an opportunity to participate in and benefit from the facility's efforts to prevent, detect and respond to sexual abuse. While onsite, the Auditor observed ICE National Detainee Handbooks in 14 languages: English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese; and DHS-prescribed Sexual Assault Awareness Information pamphlets in 9 languages: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. In addition, the Auditor observed bulletin board postings, facility posters, and Consulate contact information posted throughout the facility in both English and Spanish. During the onsite visit, intake staff indicated that the facility is advised by the releasing facility of the detainee's preferred language through the Risk Classification Assessment (RCA) documentation received. Intake staff further indicated that should the detainee not speak one of the most prevalent languages offered onsite, the facility also has access to an ERO Language Services contract to provide 24-hour telephonic interpretation services. During an interview with the PSA Compliance Manager, it was confirmed that assistance is given to detainees with disabilities based upon their disability and need. Detainees who are blind or have with limited sight disabilities will have the information for reporting sexual abuse allegations and facility information read to them by facility staff. Should a detainee present with a psychiatric or an incapacitating physical disability, the PHR will accommodate the detainee with the appropriate service by calling emergency medical services to have the detainee transported to the Reeves County Hospital for further evaluation. Once the detainee is cleared by the hospital, the facility will have the detainee returned for further processing, which includes informing the detainee of the zero tolerance policy in the manner and language in which they can understand. The PSA Compliance Manager also indicated that video remote sign language services are provided for those detainees who are deaf or hard of hearing. During interviews with ICE DOs, and an SDDO, it was confirmed that the facility allows for the use of other detainees to interpret for another detainee in matters relating to allegations of sexual abuse if the detainee expresses a preference for another detainee to provide interpretation, and the interpretation is appropriate and consistent with DHS policy.

§115.117 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): 5 CFR 731, Executive Order 10450, ICE Directive 6-7.0, ICE Personnel Program Security and Suitability, and ICE Directive 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel, require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." In addition, 5 CFR 731 requires investigations every five years. The PSA Compliance Manager confirmed during an interview that background checks are performed for all new hires and internal promotions. The policy outlines misconduct and criminal misconduct as grounds for unsuitability including material omissions or making false or misleading statements in the application. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Based on information provided in an email by the OPR PSO (A) Division Chief, information on substantiated allegations of sexual abuse involving a former employee would be provided to prospective employers upon request, unless prohibited by law. As confirmed during an interview with the SDDO, all staff have a continuing affirmative duty to disclose any misconduct as required by the standard and material omissions regarding such misconduct, or the provision of materially false information, would be grounds for termination.

The Auditor created a random list of five ICE DOs working at the PHR and submitted them to the ICE PSO. The Auditor received a written response regarding up-to-date background checks on the five ICE DOs on July 26, 2022. In addition, the APM created a random list of four contract transportation employees and submitted the list to the ICE PSO. The APM received a written response from the ICE PSO that stated, "Our system did not locate records for the names provided." Therefore, the Auditor could not confirm that the contract transportation employees received a background check prior to being hired as required in subsection (d) of the standard. As confirmed during the interview with the SDDO, all staff considered for a promotion shall be asked during the promotion application process, to disclose any previous misconduct, have an updated background investigation and impose a continuing affirmative duty to disclose any such misconduct. The one current SDDO was recently promoted and confirmed this process was followed.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The APM created a random list of four contract transportation employees and submitted the list to the ICE PSO. The APM received a written response from the ICE PSO that stated, "Our system did not locate records for the names provided." Therefore, the Auditor could not confirm that the contract transportation employees received a background check prior to being hired. To become compliant, the facility must submit documentation that all contract transportation employees received a background check prior to being hired.

§115.118 - 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): The PHR provided a written directive policy 11087.1, which addresses the requirements of the standard. Policy 11087.1 states, "When designing or developing any new ERO holding facility and in planning any substantial expansion or modification of existing holding facilities, the FOD, in coordination with the Office of Facilities Administration, Office of the Chief Financial Officer, shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect detainees from sexual abuse and assault." The PHR acquired a newly remodeled facility during November 2020. The renovated facility includes a processing area with four hold rooms. Hold rooms are in direct line of vision with ICE DOs in the processing area. A memorandum signed by the AFOD confirms the upgrades in November 2020 and that consideration was given to assist with the protection against sexual assault and abuse toward detainees while in the PHR custody.

(b): The PHR provided a written directive, Policy 11087.1, which states in part that "When installing or updating a video monitoring system, electronic surveillance system, electronic surveillance system, or other monitoring technology, consideration will be given how such technology may enhance the agency's ability to protect detainees from sexual abuse." (b) (7)(E) [redacted] There are five monitors total, four in the administration building next to the hold facility and one in the detainee processing areas for ICE DOs constant review. During the facility tour, the Auditor observed all five monitors and reviewed all footage captured by the camera system. The Auditor observed the cameras produced clear and detailed views with playback capabilities and without blind spots. (b) (7)(E) [redacted] A memorandum signed by the AFOD confirms the upgrades in November 2020 and that consideration was given to assist with the protection against sexual assault and abuse toward detainees while in the PHR custody.

§115.121 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): The PHR provided written directive, policy 11062.2, which states, "When feasible, secure and preserve the crime scene and safeguard information and evidence, consistent with ICE uniform evidence protocols and local evidence protocols in order to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." Policy 11062.2 further states, "When a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE Enforcement and Removal Operations ERO FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of the Inspector General (OIG), OPR, or the local law enforcement agency, the ICE AFOD would assign an administrative investigation to be conducted." Policy 11062.2 further states, "If the alleged victim is under the age of 18 or determined, after consultation with the relevant [Office of the Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under a State or local vulnerable persons statute, report the allegation to the designated State or local services agency as necessary under applicable mandatory reporting laws; and document his or her efforts taken under this section." The Auditor confirmed verbally with the SDDO that the Pecos, Texas Police Department (PTPD) will assist with investigations of sexual assault and sexual abuse allegations occurring at the PHR, including evidence collection. The PHR had no sexual abuse allegations reported during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

(b)(c)(d): The PHR provided policy 11087.1, which states in part that "The FOD shall coordinate with the ERO HQ, and the Agency PSA Coordinator, in utilizing, to the extent available and appropriate, community resources and services that provide expertise and support in areas of crisis intervention and counseling to address victims' needs." Policy 11087.1 further states that "where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the FOD shall arrange or refer an alleged victim detainee to a medical facility to undergo a forensic medical examination, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFE's or SANE's cannot be made available, the examination can be performed by other qualified health care personnel. If in connection with an allegation of sexual abuse, the detainee is transported for a forensic examination to an outside hospital that offers victim advocacy services, the detainee shall be permitted to use such services to the extent available consistent with security needs." The Auditor confirmed through interviews with the PSA Compliance Manager that there are no local rape crisis services provided to a detainee for advocacy services during a forensic medical examination (FME), investigative interview emotional support, or any follow-up referrals resulting from a sexual abuse allegation, or did the facility provide documentation of an attempt to enter into an agreement with an available community resource. In addition, the Auditor contacted RAINN who indicated that they do not provide hospital advocacy. Therefore, the facility is not in compliance with subsections (b) and (d) of the standard. In an interview with the SDDO, he indicated that all services will be provided only with the detainee's consent and at no cost regardless of if the victim names the abuser or cooperates with the investigation; however, the facility did not provide any documentation to confirm that Reeves County Hospital would provide services only if the detainee consents and at no cost regardless of if the victim names the abuser or cooperates with the investigation offer. In addition, the Auditor reviewed a memorandum from the AFOD that states, "In coordination with the investigative agency, Pecos, Texas medical services are to be called to administer

medical care for the victim to include transport to the local hospital to initiate any Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examination (SAFE) test on the subject." In an interview with the PSA Compliance Manager, it was indicated that a victim of sexual abuse would be taken to the Reeves County Hospital for an FME; however, the facility did not provide any documentation to confirm that Reeves County Hospital would offer an FME or a SAFE/SANE examiner. Therefore, the Auditor could not confirm compliance with subsection (c) of the standard. The Auditor called Reeves County Hospital and spoke to a staff person requesting general information. However, the staff person could not confirm services would be provided to detainees for a FME by a SAFE/SANE or advocacy services provided should the detainee consent and at no cost to the detainee.

Does Not Meet (b)(c)(d): The facility is not compliant with subsections (b), (c), and (d) of the standard. Interviews with the PSA Compliance Manager, and SDDO, could not confirm that Reeves County Hospital would offer emergency treatment, if evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent. In addition, the Auditor, could not confirm during interviews with the PSA Compliance Manager and SDDO that a forensic exam would be conducted by a SAFE or SANE where practicable, or, if SAFE's or SANE's cannot be made available, the examination would be performed by other qualified health care personnel. In an interview with the PSA Coordinator, it was confirmed that the facility did not utilize any available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling, nor did it confirm the use of a victim advocate during the forensic exam should one be requested by the detainee victim. In addition, the Auditor contacted RAINN, via telephone, and was advised that they do not offer hospital advocacy. To become compliant, the facility must enter, or attempt to enter, into an agreement with a local hospital to provide the detainee victim a forensic exam, if evidentiarily or medically appropriate, by a SAFE/SANE Nurse or other qualified medical practitioner. In addition, the facility must enter, or attempt to enter, into an agreement with a community resource to provide expertise and support in the areas of crisis intervention and counseling and to provide advocacy services, if not available through the hospital agreement, to the detainee victim during a forensic exam and during the investigation process. The facility must provide documented training to all applicable regarding the agreements entered and their responsibility to provide the detainee victim with all requirements of the standard. The facility must also provide the Auditor, if available, any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (b), (c), and (d) of the standard.

(e): The facility provided no documentation to confirm that PHR made a request to the PTPD to request they follow the requirements of paragraphs (a) through (d) of the standard when investigating allegations of sexual abuse. In addition, in an interview with the SDDO, the Auditor could not confirm that the PTPD would follow the requirements of paragraphs (a) through (d) of the standard when investigating allegations of sexual abuse.

Does Not Meet (e): The facility is not compliant with subsection (e) of the standard. The facility did not provide documentation that the PTPD was contacted to request they follow the requirements of subsections (a) through (d) of the standard. To become compliant, the facility must request that the PTPD follow the requirements of paragraphs (a) through (d) of the standard when investigating allegations of sexual abuse,

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

(a)(b)(c)(d): The PHR provided written directive, Policy 11062.2, which states, "When an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (b) (6), (b) (7)(C) Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum." Policy 11062.2 further dictates, that "The JIC shall notify the DHS Office of Inspector General (OIG)," and "the OPR shall coordinate with the FOD or SAC and facility staff to ensure evidence is appropriately secured and preserved pending an investigation by federal, state, or local law enforcement, DHS OIG, or referral to OPR." In addition, policy 11062.2 states, "All sexual abuse and assault data collected pursuant to this Directive shall be maintained for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise." Interviews with the PSA Compliance Manager confirmed Policy 11062.2 would be followed should an allegation of sexual abuse be reported by a detainee. A memorandum from the AFOD dated July 22, 2022, states that "the PHR will use the PTPD to respond and investigate any sexual abuse allegations made by a detainee while at the PHR." This was confirmed in an interview with the PSA Compliance Manager. The PSA Compliance Manager further confirmed that any allegation of sexual abuse would be promptly reported to the PSA Coordinator, and the Joint Intake Center (JIC) within two hours of any report being made. A review of the ICE website (www.ice.gov) confirms the protocols are available to the public. There were no allegations of sexual abuse reported at the PHR during the extended audit period, and therefore, compliance is determined based on Agency policy and staff interviews. The SDDO confirmed through interviews that all documentation would be maintained in accordance with ICE retention polices.

(e): The PHR provided written directive Policy 11062.2, which states in part that; "The OPR shall coordinate with appropriate ICE entities and federal, state, or local law enforcement to facilitate necessary immigration processes that ensure availability of victims,

witnesses, and alleged abusers for investigative interviews and administrative or criminal procedures, and provide federal, state, or local law enforcement with information about U nonimmigrant visa certification." On July 1, 2022, the Creative Corrections, LLC PM interviewed the Acting Section Chief of the OPR Directorate Oversight, and he confirmed that OPR Special Agents would provide the detainee victim of sexual abuse, that is criminal in nature, with timely access to U nonimmigrant status information. In a telephone call between the Creative Corrections, LLC PM and the OPR Acting Section Chief, it was further stated that if an OPR investigation determined that a detainee was a victim of sexual abuse while in ICE custody, the assigned Special Agent would provide an affidavit documenting such in support of the detainees U nonimmigration visa application. There were no allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

§115.131 – Employee, contractor, and volunteer training.

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

Notes:

(a)(b)(c): The PHR provided written directive policy 11062.2, which states in part that "All current employees required to take the training, as listed below, shall provide each employee with biennial refresher training to ensure that all employees know ICE's current sexual abuse policies and procedures," and "all newly hired employees who may have contact with individuals in ICE custody shall also take the training within one year of their entrance on duty." Policy 11062.2 further states, "All ICE personnel who may have contact with individuals in ICE custody, including all ERO officers and HSI special agents, shall receive training on, among other items: a) ICE's zero-tolerance policy for all forms of sexual abuse and assault; b) The right of detainees and staff to be free from sexual abuse or assault; c) Definitions and examples of prohibited and illegal behavior; d) Dynamics of sexual abuse and assault in confinement; e) Prohibitions on retaliation against individuals who report sexual abuse or assault; f) Recognition of physical, behavioral, and emotional signs of sexual abuse or assault, situations in which sexual abuse or assault may occur, and ways of preventing and responding to such occurrences, including: i) Common reactions of sexual abuse and assault victims; ii) How to detect and respond to signs of threatened and actual sexual abuse or assault; iii) Prevention, recognition, and appropriate response to allegations or suspicions of sexual abuse and assault involving detainees with mental or physical disabilities; and iv) How to communicate effectively and professionally with victims and individuals reporting sexual abuse or assault; g) How to avoid inappropriate relationships with detainees; h) Accommodating limited English proficient individuals and individuals with mental or physical disabilities; i) communicating effectively and professionally with lesbian, gay, bisexual, transgender, intersex, or gender nonconforming individuals, and members of other vulnerable populations; j) Procedures for fulfilling notification and reporting requirements under this Directive; k) The investigation process; and l) The requirement to limit reporting of sexual abuse or assault to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes." The Auditor chose five random ICE DOs to confirm completion of training. The Auditor reviewed the five e-learning certificates provided and the curriculum for the trainings. The certificates confirmed completion of the PREA initial, and refresher training, as required by the standard. The Auditor also reviewed training records, and the curriculum, for 10 contract transportation staff and confirmed that contract transportation staff have received all training required by subsection (b) of the standard and that all training received has been documented. The Auditor confirmed with the SDDO that the PHR does not have volunteers that come into the facility and that all training records are maintained per ICE retention policies.

§115.132 – Notification to detainees of the agency's zero-tolerance policy.

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

Notes:

The PHR provided a written directive, Policy 11087.1, which states in part that "The FOD shall ensure that key information regarding ICE's zero-tolerance policy for sexual abuse is visible or continuously and readily available to detainees (e.g., through posters, detainee handbooks, or other written formats)." According to interviews with intake ICE DOs, the facility is advised by the releasing facility of the detainee's preferred language, and then upon arrival it is confirmed and determined using the I Speak Poster: Language Identification Guide. During an interview with the SDDO it was confirmed that should a detainee arrive at the facility who does not speak English or Spanish, the facility will provide the detainee with a printed PDF of both the ICE National Detainee Handbook, available in addition to English and Spanish, in French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese; and the DHS-prescribed Sexual Assault Awareness Information pamphlet, available in addition to English and Spanish, in Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. During the tour, the Auditor observed the ICE National Detainee Handbook printed in 14 languages as well as the DHS-prescribed Sexual Assault Awareness Information pamphlet printed in 9 languages, readily available to a detainee. Intake DO staff further indicated that should the detainee not speak one of the most prevalent languages offered onsite, or by PDF printout, the facility also has access to an ERO Language Services contract to provide 24-hour telephonic interpretation services to relay the zero tolerance policy, and sexual assault allegation reporting protocols. In an interview with the PSA Compliance Manager, it was indicated that detainees who are blind or have limited sight disabilities will have the information for reporting sexual abuse allegations and facility information read to them by facility staff. Should a detainee present with a psychiatric or an incapacitating physical disability, the PHR will accommodate the detainee with the appropriate service by calling emergency medical services to have the detainee transported to the Reeves County Hospital for further evaluation and rescheduled later for deportation once the detainee is cleared. Once the detainee is cleared by the hospital, the facility will have the detainee returned for further processing which includes informing the detainee of the zero-tolerance policy in the manner and language in which they can understand. The PSA Compliance Manager also indicated that video remote interpreting services (sign language) is available for the detainee who is deaf or has limited hearing. In addition, the Auditor observed the ICE Zero-Tolerance and reporting posters provided in English and Spanish are affixed to the walls in the processing area and in the

private interview room that contained a telephone for detainee use. The Auditor reviewed the ICE website, www.ice.gov and confirmed the zero-tolerance information is available to the public.

§115.134 - 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 PHR provided written directive, Policy 11062.2 which establishes that "OPR will provide specialized training to those staff assigned to conduct administrative investigations within the PHR. The training shall cover at a minimum: interviewing sexual abuse victims, sexual abuse evidence collections in a confinement setting, the criteria and evidence required for administrative action or prosecutorial referral, and information regarding effective cross-agency coordination in the investigative process." The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. The facility provided the Specialized Training in a Confinement Setting Curriculum for Investigating Incidents of Sexual Abuse and Sexual Assault along with Certificate of Training for the SDDO, who serves as the designated facility liaison between ICE OPR and the PTPD during a sexual abuse allegation investigation by gathering any preliminary administrative incident reports needed to conduct the investigation. There were no allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy, training certificates, and staff interviews.

§115.141 - 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)(c): Policy 11087.1 states, "The FOD should ensure that before placing detainees together in a hold room, there shall be consideration of whether a detainee may be at a high risk of being sexually abused and when appropriate, shall take necessary steps to mitigate any such danger to the detainee." According to interviews with the ICE DOs, ICE screens detainees for special vulnerabilities prior to being transferred into the facility, which is reflected on a Risk Classification Assessment (RCA) screening form. The RCA screening takes into consideration whether the detainee has a mental, physical, or developmental disability, the age of the detainee, whether the detainee has been previously incarcerated or detained, the nature of the detainee's criminal history, and whether the detainee has self-identified as LGBTI or gender nonconforming. Additional questions are asked during the intake process to ensure compliance with the standards which include whether the detainee has any convictions for sex offenses against an adult or child, the detainee's own concerns about his or her physical safety and any previous sexual victimization. All information is recorded in the RCA admission paperwork. Per interviews with ICE DOs, no detainees are brought into the facility from the street for processing. Detainees arrive from other facilities and with background information compiled, which is then incorporated into the intake screening process and questions once on site by using the RCA. Five random admission files and documents were reviewed by the Auditor on site, confirming all required information is taken into consideration to access detainees' risk for sexual victimization during the risk screening.

(b): Policy 11062.2 states, "The FOD shall ensure that detainees who may be held overnight with other detainees are assessed to determine their risk of being either sexually abused or sexually abusive, to include being asked about their concerns for their physical safety." According to the PAQ, the PHR does not house detainees overnight; however, if a detainee were to be held overnight due to unforeseen circumstances, the facility would utilize the information from the RCA screening form in conjunction with additional screening questions asked by staff during the intake process to identify high risk or vulnerable detainees during intake.

(d): Per ICE Policy 11087.1, "For detainees identified as being at high risk for victimization, the FOD shall provide heightened protection, including continuous direct sight and sound supervision, single-housing, or placement in a hold room actively monitored on video by a staff member sufficiently proximate to intervene, unless no such option is feasible." Interviews with ICE DOs confirmed staff ask new detainees about any prior sexual abuse victimization, violent offense histories, and detainee histories of institutional violence or abuse per the policy. If there is any affirmative identification of a detainee being a sexual abuse victim or abuser, they are placed in a holding room by themselves. Due to the short term stay of detainees, holding rooms at the PHR are generally only occupied by one detainee at a time unless a large group is brought in together. If a single holding room would not be available, the information obtained from the RCA screening form in conjunction with additional screening questions asked by staff during the intake process would determine which occupied holding room the detainee would be placed to ensure the safest environment for the detainee. Detainees are also asked how they identify their sexual orientation, which is recorded on the RCA. Any detainees who identify in the LGBTI community will be housed in a hold room alone to ensure their safety. Regular 15 minutes checks are conducted and recorded in the log. All hold rooms at the PHR are monitored with video surveillance and are in direct line of vision of any ICE DO in the processing area to provide detainees that may be at high risk the heightened protection needed.

(e): ICE Policy 11087.1 requires, "all holding facilities to place strict controls on the dissemination of sensitive information detainees provided during the screening procedures." Interviews with ICE DOs, and the PSA Compliance Manager, confirmed the policy and the facility's practice of strict confidentiality on a "need to know basis" is adhered to which is in alignment with the standard provisions.

The PSA Compliance Manager further indicated that all information is stored on the facility computer system and access is granted only to the ICE employees.

§115.151 - Detainee reporting.

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

Notes:

(a)(b)(c): The PHR provided a written directive, Policy 11087.1, which addresses the requirements of the standard and states in part that "The FOD shall ensure that detainees are provided instructions on how they can privately report incidents of sexual abuse, retaliation for reporting sexual abuse, or violations of responsibilities that may have contributed to such incidents to ERO personnel," and "the FOD shall also implement procedures for ERO personnel to accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports." Policy 11087.1 further states, "The FOD shall ensure that detainees are provided with instructions on how they can contact the DHS/Office of the Inspector General (OIG) or as appropriate, another public or private entity which is able to receive and immediately forward detainee reports of sexual abuse to agency officials. Also, to confidentially, and if desired, anonymously, report these incidents." All areas in which a detainee may be while at the PHR, including the private interview room and processing area walls, contains DHS PREA Zero-Tolerance posters with information in English and Spanish, which detail that detainees can report to any PHR staff member either verbally, or in writing, and to the DHS OIG or Consulate via telephone. During interviews with the SDDO, it was confirmed that the facility provides the detainee with information in their preferred language either by a hard copy of the ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness Information pamphlet or through oral interpretation by way of the ERO Language Services. The facility provides information for RAINN should a detainee wish to seek emotional advocacy services; however, RAINN is not a means for a detainee to report as confirmed through a telephone call placed by the Auditor. All interviewed ICE DOs confirmed their understanding to immediately report any allegation of sexual abuse reported by a detainee in writing, or verbally, while in their custody to their supervisor. As confirmed during DO interviews, all reported allegations would immediately be documented and forwarded to the SDDO on duty. During the onsite visit, the Auditor attempted calls on the telephone privately used by detainees in the interview room and confirmed that a detainee can make reports anonymously to the DRIL, JIC, and OIG without using their Non-Citizen Number, name, or a PIN number through the utilization of a direct line.

§115.154 - Third-party reporting.

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

Notes:

The PHR provided a written directive, Policy 11087.1, which addresses the requirements of the standard and states in part that "The FOD shall also implement procedures for ERO personnel to accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports." Through direct observation of holding room ICE Zero-Tolerance posters, ICE DO staff interviews, and by directly visiting the provided websites, it was confirmed that the PHR has established methods to receive third party reports of sexual abuse. Third parties may report via telephone, or email, using the information located on the website at https://www.ice.gov/contact and https://www.ice.gov/PREA. The Auditor attempted to test the third-party reporting link provided on the ICE website and the test submission was successful.

§115.161 - Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): The PHR provided a written directive, Policy 11062.2, which addresses the requirements of the standard and states in part that "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The supervisor, or designated official, shall report the allegation to the FOD or [Special Agent in Charge] SAC, as appropriate. Apart from such reporting, ICE employees shall not reveal any information related to a sexual abuse allegation to anyone other than the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff, or to make medical treatment, investigation, law enforcement, or other security and management decisions." The Agency has also provided a memorandum entitled "Employee Obligation to Report Corruption and Misconduct," dated November 8, 2021, by Acting Deputy Director (b) (6), (b) (7)(C) This memo reiterates the types of misconduct allegations that employees must report to the JIC, OPR, or the DHS OIG and those types of allegations that should be referred to local management. "Employees should report allegations of substantive misconduct or serious mismanagement to the JIC, OPR, or DHS OIG." Listed in this memo as a substantive misconduct is "Physical or sexual abuse of a detainee or anyone else." A review of policy, training curriculums, and staff interviews with the SDDO, and ICE DOs, confirm that the Agency requires all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, any retaliation against detainees or staff who reported or participated in an investigation about such an incident that may have occurred to a detainee, and not to disclose any related information to anyone other than to the extent necessary. Further, the interviews confirmed that staff are aware they may report any misconduct outside of their chain of command by calling or writing the JIC, the DHS OIG, or the third-party methods for reporting located on the ICE website.

(d): Policy 11062.2, states in part; "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of the Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable

mandatory reporting law; and to document his or her efforts taken under this section." Interviews with ICE DOs indicated that all reported allegations involving a vulnerable adult would immediately be reported to the SDDO on duty who would in turn immediately report the allegation to the OIG; however, they did not confirm that they would coordinate with the OPLA OCC or report the incident to any local authority having oversight as necessary under applicable mandatory reporting laws, as required by policy 11062.2. Interviews with ICE DOs and SDDO further confirmed the facility did not house juveniles. There were no allegations of sexual abuse reported at the PHR during the extended audit period.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. Interviews with ICE DOs indicated that all reported allegations involving a vulnerable adult would immediately be reported to the SDDO on duty who would in turn immediately report the allegation to the OIG; however, they did not confirm that they would coordinate the OPLA OCC or report the incident to any local authority having oversight as necessary under applicable mandatory reporting laws, as required by policy 11062.2. To become compliant, the facility must train all applicable staff on the requirements of policy 11062.2 which state they implement a practice that "If alleged victim under the age of 18 or determined, after consultation with the relevant OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section" and document said training. In addition, the facility must provide the Auditor, if applicable, all allegations of sexual abuse investigative files involving a vulnerable adult that occur during the Corrective Action Period (CAP) period.

§115.162 – Agency protection duties.

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

Notes:

The PHR provided a written directive, Policy 11062.2, that addresses the requirements of the standard and states in part that "If an ICE employee has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." Interviews with ICE DOs confirmed their knowledge and understanding of the requirement to report, separate the detainee from the threat, and place them under direct supervision. There were no allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

§115.163 - 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 PHR provided a written directive, Policy 11062.2, which addresses the requirements of the standard and states in part; "If the alleged assault occurred at a different facility from the one where it was reported, ensure that the administrator at the facility where the assault is alleged to have occurred is notified as soon as possible, but no later than 72 hours after receiving the allegation and document such notification." The interview with the PSA Compliance Manager, confirmed the awareness of the requirement to notify the appropriate office of the Agency or the administrator of the facility where the alleged abuse occurred within the 72-hour requirement and that all notifications regarding an allegation of sexual abuse are noted in the case record of the detainee. The PSA Compliance Manager further confirmed that should the PHR receive notice that a detainee at the PHR alleges to have been sexually abused while confined at another facility the PHR would immediately refer the allegation for investigation as required by the standard. There were no allegations of sexual abuse reported during the extended audit period; and therefore, compliance is based on Agency policy and staff interviews.

§115.164 - Responder duties.

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

Notes:

(a): The PHR provided a written directive, Policy 11087.1, which addresses the requirements of the standard and states in part that "The FOD shall ensure that upon learning of an allegation that a detainee was sexually abused, the first responder, or his or her supervisor shall; separate the alleged victim and abuser, preserve and protect to the greatest extent possible any crime scene until appropriate steps can be taken to collect any evidence, and if the sexual abuse occurred within a time period that still allows for the collection of physical evidence, requests the alleged victim not to take any actions that could destroy physical evidence. These actions would include washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the sexual abuse occurred within a time that still allows for the collection of physical evidence, ERO staff would ensure that the alleged abuser does not to take any actions that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating." It was confirmed through interviews with ICE DOs, that they are aware of their responsibilities to respond when learning of an allegation of sexual abuse toward a detainee. ICE DOs were able to explain the steps necessary as a first responder to ensure the safety of a detainee after an allegation of sexual abuse.

(b): Policy 11087.1 states, "If the first responder is not a security staff member, the responder shall request the alleged victim not to take any actions that could destroy physical evidence, and then notify security staff." Due to their transport assignment, there were zero La Salle contract staff available to interview; however, the training curriculum provided, and the training acknowledgement signed by contract transportation staff, confirmed their knowledge in their responsibilities as a non-security staff first responder. The PHR does not have any volunteers that have contact with any detainees.

§115.165 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): The PHR provided a written directive, Policy 11087.1, which addresses the requirements of the standard and states in part that "The FOD shall ensure a coordinated, multidisciplinary team approach to responding to allegations of sexual abuse occurring in holding facilities or in the course of transit to or from holding facilities, as well as to allegations made by a detainee at a holding facility of sexual abuse that occurred elsewhere in ICE custody." It was confirmed through interviews with the PSA Compliance Manager and ICE DOs that they are aware of their responsibilities to respond in conjunction with the facility coordinated response to sexual abuse toward a detainee. When conducting the interviews with the PSA Compliance Manager, and ICE DOs, they indicated that they would separate the victim from the abuser, preserve the scene, contact medical personnel at the Reeves County Hospital, secure the area, and notify a supervisor and the PTPD. There were zero allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

(b)(c): Policy 11087.1, requires "If a victim is transferred from a holding facility to a detention facility or to a non-ICE facility, the FOD shall inform the receiving facility of the indecent and the victim's potential need for medical or mental health care of victim services." The PSA Compliance Manager indicated during interviews that if a detainee being transferred was a victim of sexual abuse, the PHR staff would provide the receiving facility any information regarding the sexual abuse allegation, including the victim's need for any medical or social services follow-up; however his interview could not confirm that should the detainee be transferred to a facility not covered by paragraph (b) of the standard that the facility will take into consideration the detainee's request not to have his/her potential need for medical or social services shared with the receiving facility. There were zero allegations of sexual abuse reported at the PHR during the extended audit period.

Does Not Meet (c): Policy 11087.1, as it relates to standard 115.165 is not consistent with the standard. The policy as it relates to the coordinated response protocol does not include "unless the victim requests otherwise." Although the other Agency directive, 11062.2, is compliant with the DHS PREA Standards, if hold rooms are using 11087.1 as their coordinated response protocol, or even a combination of both, then they would be deficient. To become compliant, the Agency must update their written institutional plan to contain the required verbiage as written in 115.165 subpart (c). The facility must provide documented training of applicable staff on the updated written institutional plan. In addition, the facility must provide the Auditor with any investigation, medical, and detainee files regarding any detainee victim of sexual abuse transferred during the CAP period.

§115.166 - 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 PHR provided a written directive, Policy 11062.2, which addresses the requirements of the standard and states in part that "The FOD shall ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring detainee contact pending the outcome of an investigation." The interview with the SDDO confirmed staff, and contract transport staff, would be removed from any duties in which detainee contact was involved pending the outcome of an investigation in conjunction with the written directive. There were no allegations of sexual abuse reported during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

§115.167 - Agency protection against retaliation.

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

Notes:

The PHR provided a written directive, Policy 11062.2, which states in part that "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or for participating in sexual activity as a result of force, coercion, threats, or fear of force." The interview with the PSA Compliance Manager confirmed that any person, including a detainee, would be protected from retaliation when a party to an allegation of sexual abuse of a detainee as outlined in the policy. There have been zero allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

§115.171 - Criminal and administrative investigations.

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

Notes:

(a): The PHR provided written directive, Policy 11062.2, which addresses the requirements of the standard. The policy states in part that "The FOD shall ensure that the facility complies with the investigation mandates established by PBNDS 2011, Standard 2.11, as well as other relevant detention standards and contractual requirements including by conducting a prompt, thorough, and objective investigation by qualified investigators." The interview with the PSA Compliance Manager confirmed that all administrative investigations are referred to ICE OPR and potentially further referred to ICE ERO for action and that all detainee-on-detainee, staff-on-detainee, and contract staff-on-detainee sexual abuse allegations are referred to the PTPD when criminal in nature. PHR does not have volunteers. There were zero allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

(b)(c)(d): In accordance with policy 11062.2, "The FOD shall ensure that the facility complies with the investigation mandates established by the Performance-Based National Detention Standards (PBNDS) 2011, Standard 2.11, as well as other relevant detention standards." PBNDS 2011 states in part that; "Upon conclusion of a criminal investigation where the allegation was substantiated, or in instances where no criminal investigation has been completed, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Substantiated allegation means an allegation that was investigated and determined to have occurred. Unsubstantiated allegation means an allegation that was investigated, and the investigation produced insufficient evidence to make a final determination as to whether the event occurred. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The ICE Office of Professional Responsibility will typically be the appropriate investigative office within DHS, as well as the DHS OIG in cases where the DHS OIG is investigating." PBNDS 2011, Standard 2.11 further states, "The facility shall develop written procedures for administrative investigations, including provisions requiring; preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviewing alleged victims, suspected perpetrators, and witnesses, reviewing prior complaints and reports of sexual abuse 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 alleges sexual abuse 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, and retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years" and "such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation. The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." In an Interview with the PSA Compliance Manager, it was confirmed that if a sexual abuse allegation were reported, it would immediately be referred to ICE OPR for investigation. There were zero sexual abuse allegations reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

(e) Policy 11062.2 dictates that "The facility fully cooperates with any outside agency investigating and endeavor to remain informed about the progress of the investigation." The interview with the PSA Compliance Manager confirmed that the facility would fully cooperate with any outside agency as required by this policy and that the progress of any ongoing investigations would be updated either via telephone or email correspondence with the investigating agency. There were zero allegations of sexual abuse reported to the PTPD during the extended audit period; and therefore, compliance is determined by Agency policy and staff interviews.

§115.172 - 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 PHR provided a written directive, Policy 11062.2, which states in part that; "the OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse and may not be terminated solely due to the departure of the alleged abuser or victim from employment or control of ICE." The interview with the PSA Compliance Manager confirmed the PHR does not conduct administrative investigations and that only preliminary administrative documentation is produced immediately preceding any incident. This information is turned over to the investigator at ICE OPR and/or the PTPD. There were zero allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

§115.176 - Disciplinary sanctions for staff.

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

Notes:

(a)(c)(d): The PHR provided a written directive, Policy 11062.2, which addresses the requirements of the standard and states in part; "Upon receiving a notification from a FOD, or Special Agent in Charge (SAC), of the removal or resignation in lieu of removal of staff violating agency or facility sexual abuse and assault policies, the OPR will report that information to the appropriate law enforcement agencies unless the activity was clearly not criminal and make reasonable efforts to report that information to any relevant licensing bodies, to the extent known." The interview with the PSA Compliance Manager confirmed the disciplinary outcome of removal from service for violations of the sexual abuse policies and making attempts to inform all licensing agencies because of substantiated allegations. There were no allegations of sexual abuse reported at PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

§115.177 - 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): The PHR provided a written directive, Policy 11062.2, which addresses the requirements of the standard and states in part; "The FOD shall ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring contact with detainees pending the outcome of an investigation." The PSA Compliance Manager confirmed during his interview that any contractor who may have violated other provisions within the standards would be removed from all duties requiring contact with detainees pending the outcome of an investigation. The PSA Compliance Manager further confirmed that all allegations of sexual abuse would be immediately reported to the SDDO on duty, the PTPD, and the JIC for further review and investigation. In addition, the PSA Compliance Manager confirmed that there are no volunteers at the PHR. There were no allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on Agency policy and staff interviews.

§115.182 - Access to emergency medical services.

Outcome: Does Not Meet Standard (requires corrective action)

Notes:

(a)(b): The PHR provided a written directive, Policy 11087.1, which addresses the requirements of the standard and states in part; "The FOD shall ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The FOD shall coordinate with ERO HQ, and the Agency PSA Coordinator, in utilizing, to the extent available, any community resources and services that provide expertise and support in the areas of crisis intervention and counseling to address the victims' needs." Policy 11087.1 further provides that "victims of sexual abuse shall be provided emergency medical and mental health services and any ongoing care necessary. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost regardless of whether the victim names the abuse or cooperates with any investigation arising out of the incident." The interview with the PSA Compliance Manager confirmed that a detainee alleging sexual abuse and in need of emergency care would be taken to the Reeves County Hospital; however, the facility did not provide any documentation to confirm that Reeves County Hospital would ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care or that the treatment services, both emergency and ongoing, will be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor called Reeves County Hospital and spoke to a staff person requesting general information. However, the staff person could not confirm services would be provided to detainees for a FME by a SAFE/SANE or advocacy services provided should the detainee consent and at no cost to the detainee. Therefore, the Auditor could not confirm compliance with subsections (a) and (b) of the standard. There have been no allegations of sexual abuse during the extended audit period.

Does Not Meet (a)(b): The facility is not compliant with subsections (a) and (b) of the standard. The interview with the PSA Compliance Manager, confirmed that a detainee alleging sexual abuse and in need of emergency care would be taken to Reeves County Hospital, however, the facility did not provide any documentation that the hospital would ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care or that the treatment services, both emergency and ongoing, will be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. To become compliant the facility must enter, or attempt to enter, an agreement with a local hospital to provide detainee victims of sexual abuse or assault with timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and that the treatment services, both emergency and ongoing, will be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. In addition, the facility must provide the Auditor, if applicable, with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (a) and (b) of the standard.

§115.186 – Sexual abuse incident reviews.

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

Notes:

(a): The PHR has provided a written directive, Policy 11087.1, which addresses the requirements of the standard and states in part; "A sexual abuse and assault incident review shall be conducted at the conclusion of every investigation of sexual abuse or assault occurring at a holding facility and unless the allegation was determined to be unfounded, a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and assault. Such review shall ordinarily occur within 30 days of the EROs receipt of the investigation results from the investigating authority. The FOD shall implement the recommendations for improvement, or shall document its reasons for not doing so, in written justification. Both the report and justification shall be forwarded to the Agency PSA Coordinator." During the interview with the PSA Compliance Manager, it was confirmed that the incident review report and recommendations, if any, would be conducted and documented within the 30-day timeframe. The report and/or recommendations would subsequently be sent to the AFOD for implementation, improvement, or written justification for not implementing the recommendations. In addition, the PSA Compliance

Manager confirmed both the report and response is forwarded to the Agency PSA Coordinator. There were no allegations of sexual abuse reported at the PHR during the extended audit period; and therefore, compliance is determined based on agency policy and staff interviews.

§115.187 – Data collection.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a): The PHR has provided a written directive, Policy 11062.2, which states in part that "data collected pursuant to this Directive shall be securely retained in accordance with agency record retention policies and the agency protocol regarding investigation of allegations, (see PBNDS 2011 Standard 2.11). All sexual abuse and assault data collected pursuant to this Directive shall be maintained for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. Investigative files would be retained at the OPR Headquarters in the Agency's online case management system (JICMS)." The PSA Compliance Manager confirmed during interviews that the information would be maintained according to the written directive provided. There have not been any incidents or allegations of sexual abuse at the PHR during the extended audit period; and therefore, compliance is based on agency policy and staff interviews.

§115.193 – Audits of standards.
Outcome: Not Low Risk
Notes:

The PREA Audit at the PHR was the second audit for this facility. After a careful review, it was determined that the facility is not in compliance with six of the standards; and therefore, not in compliance with the DHS PREA Standards. PHR only holds detainees up to 12 hours, and there have not been any allegations of sexual abuse during the extended audit period; however, the Auditor must take into consideration the areas of non-compliance which include both policy and procedural issues. Therefore, the Auditor has determined that the facility is not low risk.

§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)(i): The Auditor was given access to and observed all areas of the facility. The Auditor was unable to conduct any detainee interviews due to detainees being placed in congregate quarantine upon their arrival due to Covid-19 precautions. The Auditor was given access to all ICE staff but was unable to interview contract transport staff due their duty requirement to drop off detainees at the facility and immediately continue their route.

(e): The Auditor was provided with all relevant documents required to conduct a thorough PREA compliance audit of the PHR.

(j): Audit notices were posted in each holding unit and individual holding room giving the detainees an opportunity to confidentiality correspond with the Auditor should they desire. The Auditor did not receive any correspondence from a detainee at the PHR.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	23
Number of standards not met:	6
Number of standards N/A:	1
Number of standard outcomes not selected (out of 31):	0
Facility Risk Level:	Not Low Risk

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.

Marlean Ames 9/14/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/22/2022

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/22/2022

Assistant Program Manager's Signature & Date