PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	1/11/2022	**To:**	1/13/2022
AUDITOR INFORMATION			
Name of auditor:	Cicily Harrington	**Organization:**	Creative Corrections, LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Philadelphia Field Office
Field Office Director:	Brian McShane
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	114 North 8th Street, Philadelphia, PA 1907
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:	Pike County Correctional Facility		
Physical address:	175 Pike County Boulevard, Lords Valley, PA 18428		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	215-656-7164		
Facility type:	IGSA		
PREA Incorporation Date:	12/19/2019		
Facility Leadership			
Name of Officer in Charge:	Craig Lowe	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	570-775-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Lieutenant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	570-775-(b) (6), (b)

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Pike County Correctional Facility (PCCF) was conducted on January 11-13, 2022, by U.S. Department of Justice (DOJ) and DHS, certified PREA Auditor Cicily Harrington, 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 Custom Enforcement (ICE) PREA Program Manager, (b) (6), (b) (7)(C) and Assistant ICE Program Manager (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility's (OPR) External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. PCCF is a county government facility governed by the Prison Board and Commissioner's Office and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult male and female detainees who are pending immigration review or deportation and is located in Lords Valley, PA. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the PCCF are from Mexico, Dominican Republican, and Guatemala. The facility does not house juveniles or family detainees. This was the first DHS ICE PREA audit for the PCCF and included a review of the 12-month audit period from January 2021 – January 13, 2022. Approximately four weeks before the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's PAQ, facility policies, and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA is Standard Operating Procedures (SOP) 1517 Sexual Misconduct/Assault. All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Lead Auditor for the interviews with staff and detainees. The Lead Auditor also reviewed the facility's website, pikepa.org.

There was a total of three reported sexual abuse investigations during the audit period. Two of the investigations were completed and closed unfounded. The third investigation is ongoing. Both closed investigations consisted of staff-on-detainee alleged sexual abuse. The facility has one trained investigator to complete all allegations of sexual abuse.

On January 11, 2022, an entrance briefing was held in the PCCF administrative conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing, and then turned it over to the Auditor.

In attendance were:

- Craig Lowe, Warden
- (b) (6), (b) (7)(C) Assistant Warden
- (b) (6), (b) (7)(C) Lieutenant
- (b) (6), (b) (7)(C) ICE ERAU Team Lead
- (b) (6), (b) (7)(C) ICE ERAU Inspections and Compliance Specialist
- Cicily Harrington, Certified PREA Auditor, Creative Corrections, LLC

The Auditor introduced herself and provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. She further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews. On the first day of the audit, there were 45 detainees housed at PCCF. The current rated design capacity for the facility is 377 detainees. The facility also houses United States Marshal Service (USMS) inmates and male and female Pike County jail inmates. There is no comingling of the populations. Each of the populations is satellite-fed on their respective living units as PCCF has no dining room facilities. PCCF is comprised of one building with nine open bay dorm housing units, six medical beds, 10 multi-cell occupancy units, 13 restrictive housing cells, and two mental health beds. The facility's average daily population (ADP) is 114 male detainees and five female detainees. PCCF maintains a staff compliment of 80 employees, contractors, and volunteers.

Upon the Auditor's arrival at PCCF, the Auditor was informed of the new emerging outbreak of COVID-19 pandemic and its effects on staff and detainees. During the course of the site visit, the Auditor conducted informal interviews with staff and detainees, questioning them on their knowledge of PREA. At the conclusion of the tour, the Auditor was provided with a roster of staff and detainees and randomly selected personnel from each shift to participate in formal interviews. Due to the majority of the detainee population in quarantine or isolation, the Auditor could only interview 12 detainees (eight random, three limited English proficient (LEP), and one detainee who reported a history of sexual abuse). A total of 12 staff and 3 contract staff were interviewed, including (the Warden, Assistant Warden, Prevention of Sexual Assault (PSA) Compliance Manager, Human Resources, Training Supervisor, Classification Coordinator, ICE Supervisory Detention and Deportation Officer (SDDO), five random (Correctional Officers), and three contractors (two Medical and one Mental Health staff).

Full compliance standards were contingent upon the on-site review of observations of the facility's operational practices during the facility tour, any additional documentation review, and interviews of staff and detainees to determine all subparts of the standard were appropriately addressed per the standard's requirement and upon the Auditor's review of notes and information.

On January 13, 2022, an exit briefing was conducted by the Lead Auditor in the Administrative Conference Room. In attendance were:

- Craig Lowe, Warden
- (b) (6), (b) (7)(C) Assistant Warden
- (b) (6), (b) (7)(C) Lieutenant
- (b) (6), (b) (7)(C) ICE ERAU Team Lead
- (b) (6), (b) (7)(C) ICE ERAU Inspections and Compliance Specialist
- Cicily Harrington, Certified PREA Auditor, Creative Corrections, LLC

The Auditor briefly discussed staff and detainee knowledge of PCCF PREA zero-tolerance policy. The Auditor informed those present of some compliance concerns; however, advised that it was too early in the process to formalize an outcome of the audit. The Auditor also advised that all submitted documentation and interview notes conducted with staff and detainees will be reviewed. The ICE ERAU Team Lead 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: 2

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

Number of Standards Met: 15

§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.51 Detainee reporting
§115.54 Third-party reporting
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.65 Coordinated response
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.77 Corrective action for contractors and volunteers
§115.81 Medical and mental health assessments; history of sexual abuse
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 24

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.61 Staff reporting duties
§115.64 Responder duties
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.71 Criminal and Administrative Investigations
§115.76 Disciplinary sanctions for staff
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(c): The Auditor reviewed Standard Operating Procedure (SOP) 1517 (Sexual Misconduct/Assault) which mandates zero-tolerance toward all forms of sexual abuse and outlines PCCF's approach to prevent, detect, and respond to sexual abuse. The approach to accomplish this goal is through hiring practices and ensuring employees, contractors, volunteers, and detainees are informed of the facility's zero-tolerance policy and procedures pursuant to sexual abuse and sexual misconduct. The random staff and detainees interviewed indicated they are aware of the facility's sexual abuse policy. However, the facility did not provide the Auditor with documentation confirming the agency reviewed and approved PCCF's zero-tolerance policy.

(d): The Auditor determined compliance with this subpart of the standard based on a review of SOP 1517 that requires the PSA Compliance Manager "to develop, implement, and oversee facility efforts to comply with PREA standards." During his interview, the PSA Compliance Manager confirmed that he is the designated local point-of-contact for the Agency ICE Field Office and ICE PSA Coordinator; and verified he has sufficient time and authority to oversee the facility's sexual abuse prevention and intervention policies and procedures. The Auditor reviewed PCCF's organizational chart, which demonstrates the PREA Compliance Manager reports directly to the Assistant Warden, who reports directly to the Warden.

Does Not Meet (c): The facility does not meet standard 115.11 (c). The subsection requires that the Agency reviews and approves the facility's zero-tolerance policy. To become compliant the facility must forward SOP 1517 to the Agency for review and approval.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) The auditor reviewed PCCF's SOP 313 (Review of Staffing Requirements) that state, "The Assistant Warden shall prepare an annual comprehensive staffing analysis to determine staffing requirements. This analysis and any recommendations will be reviewed by the PSA Compliance Manager and submitted to the Warden. Staffing levels are based on generally accepted detention and correctional practices, findings from inspections, all components of the physical plant, composition of the detainee population, number and placement of supervisory staff, programs, applicable laws, regulations, standards, prevalence of substantiated and unsubstantiated incidents of sexual abuse and any other relevant factors." The Auditor reviewed the facility's Staff Coverage Plan Worksheet, which demonstrated adequate supervision of detainees on all three shifts. The Auditor reviewed the facility's staffing analysis which consisted of line staff, mid-level staff, upper-level staff, medical contractors, and maintenance staff on all three shifts demonstrating adequate levels of detainee supervision. The Auditor reviewed a checklist, confirming that the Annual Review and facility Post Orders for 2021 had been completed and updated. The PSA Compliance Manager verified the comprehensive guidelines are developed by the Warden and Assistant Warden and the Commissioner by considering "the physical layout, composition of staff to detainee, and determination of extra staff and mirrors." The Auditor toured the facility and found several blind spots in the following areas where there is at least a ratio of one detainee to one staff or two detainees to one staff: 1) laundry room, 2) barbershop, and 3) dry storage area in the kitchen. (b) (7)(E) [redacted] (b) (7)(E) After the facility audit, the Auditor was provided a quote, a purchase order, and email correspondence between the Warden and the Sr. Account Manager (dated 1/19/22), demonstrating the initiation of implementing video surveillance in identified blind spots.

Does Not Meet (a): The Auditor identified several blind spots in areas where detainees and staff are consistently unsupervised; therefore, the Auditor could not confirm compliance with the standard that requires the facility to ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. To confirm compliance, the facility must change its policy and practice to ensure detainees and staff are not left unattended in those identified areas and install the video surveillance cameras that were requested by the Warden on January 19, 2022, as noted above.

(d) The Auditor determined compliance with this subpart of the standard based on review of SOP 1002 (Housing Unit Operations) which states, "Housing unit officers are to conduct security inspections no more than 30 minutes apart." Five Correctional Officers

were interviewed and all five reported they conduct 30-minute unannounced security inspections. The PSA Compliance Manager reported that the facility maintains adequate supervision of all detainees and that staff conduct 30-minute unannounced security inspections. The Warden stated that 30-minute security checks are conducted to ensure general safety and sexual safety of all detainees. While onsite, the Auditor reviewed 19 security inspection reports throughout the housing units and auxiliary posts indicating 30-minute security inspections had been conducted by line staff on all three shifts. In addition, the Auditor reviewed nine logbook excerpts for random days and observed supervisory security inspections on all three shifts.

Recommendation (d): In accordance with the Auditor's review of the housing unit logbooks and staff interviews, the Auditor determined compliance with subpart (d) of this standard. However, the Auditor recommends the facility update the policy and post orders to reflect "unannounced" security inspections and train staff on the policy change.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

PCCF does not accept juveniles or family detainees. This was confirmed in the PAQ and with interviews conducted with the Warden, PSA Compliance Manager, Correctional Officers, and personal observations while onsite.

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

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

Notes:

(b)(c)(d): The Auditor determined compliance with these subparts of the standard based on review of SOP 1012.6 (Inmate/Detainee Searches) that requires "cross-gender pat searches to be completed by the same gender unless there is an exigent circumstance and at that time, an incident report would be submitted to the Shift Commander." The Auditor reviewed SOP 1517 that states, "Cross-gender searches are prohibited unless approved by the Shift Commander." The Training Supervisor stated during his interview that cross-gender pat-down searches of male and female detainees are only conducted in emergency situations. The PSA Compliance Manager verified through interview and written memorandum (dated 11/16/21), that there was no cross-gender pat-down searches of male or female detainees conducted at PCCF within the past 12 months. Five Correctional Officers were interviewed and all five reported they have never conducted or witnessed a cross-gender pat search at PCCF.

(e)(f): The Auditor determined compliance with this subpart of the standard based on review of SOP 1012.6 that states, "Cross-gender strip searches are prohibited except in unforeseen circumstances and at that time, the Shift Commander would have to give approval. Body cavity searches are only performed at a hospital by a licensed physician. Body cavity searches are documented." However, policy does not indicate cross-gender strip searches are documented. The auditor reviewed a memorandum (dated 12/02/21) from the PSA Compliance Manager stating, "The TEK 84 Body Scanner has been implemented to conduct searches of detainees and that there have been no strip searches or visual body cavity searches of detainees within the past 12 months." Also, the Auditor reviewed a memorandum (dated 12/20/21) from the Maintenance Supervisor informing that the TEK 84 Body Scanner has been installed to take the place of strip searches at PCCF. Five Correctional Officers were interviewed and all five reported they have never conducted or witnessed a cross-gender strip search or visual body cavity search of any detainee at PCCF. One of the Correctional Officers explained that the TEK 84 Body Scanner is now being used to search detainees instead of having to conduct strip searches.

Recommendation (f): The Auditor recommends the facility update SOP 1517 to include that staff document cross-gender strip searches.

(g): The Auditor reviewed SOP 1002 (Housing Unit Operations) that mandates, "Staff of the opposite gender to announce their presence when entering a housing unit." Five Correctional Officers were interviewed and all five stated prior to them entering a housing unit that houses detainees of the opposite gender, they announce their presence. All five Correctional Officers verified they have never seen detainees of the opposite gender shower, use the bathroom, and change clothing. The Auditor (female) was accompanied by the Audit Team Lead (female), the PSA Compliance Manager and the Audit Team Lead's partner, and upon entering the male detainee housing unit, there was no announcement of the opposite gender entering the unit; and therefore, the auditor announced, "female presence." (b) (7)(E) [redacted] When asked, the medical intake staff and the Warden informed that when a detainee is being examined by medical staff, the portable (three-faced) medical privacy screen is set up around the examination table to ensure privacy. The Auditor observed the medical privacy screen in the medical area during the audit tour. (b) (7)(E) [redacted] The Auditor entered the restrictive housing unit, although there were no detainees currently housed, the auditor observed an exposed gated shower door with no curtain or covering. The auditor was advised that a curtain would be placed in the shower area to prohibit cross-gender viewing if the unit was occupied. The auditor recommended they keep the shower curtain in place in case they must immediately place a detainee into restrictive housing.

Does Not Meet (g): The facility was unable to demonstrate how it ensures the privacy of detainees to shower, use the bathroom, and change clothing without staff of the opposite gender viewing. To confirm compliance, the auditor recommends the facility re-train

staff on announcing their presence or the presence of anyone who is of the opposite gender prior to entering a housing unit. In addition, to prohibit staff of the opposite gender from viewing detainees while using the bathroom in the intake observational cells, the facility must incorporate a blocking or shading mechanism into their camera system to shade the toilet area thus allowing the detainee privacy when using the bathroom. The facility must provide documentation through pictures that the addition of the blocking or shading mechanism has been added.

Recommendation (g): The Auditor recommends an update in policy to require medical staff document each time the medical privacy screen is used or reposition the video camera so that the examination table is not viewed/recorded. In addition, the Auditor observed an exposed gated shower door with no curtain or covering in the unoccupied restrictive housing unit and recommends the facility to install and keep a curtain in the shower area at all times to prohibit cross-gender viewing if the unit became occupied.

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

(i): The Auditor determined compliance with this subpart of the standard based on review of SOP 1012.6 (Inmate/Detainee Searches) that states," Transgender and intersex detainees will not be searched or physically examined to determine their genital status." The PCCF's Searches Lesson Plan states, "if staff is unable to determine the detainee's genital characteristics, staff will refer the detainee to medical to determine gender characteristics through further conversations with the detainee and review of documentation." The PSA Compliance Manager, Training Supervisor, and five Correctional Officers verified staff is prohibited from searching a transgender or intersex detainee to solely determine the detainee's genital characteristics. The Auditor attempted to interview a transgender onsite; however, no transgender or intersex detainees were housed at PCCF during the onsite audit.

(j) The Auditor determined compliance with this subpart of the standard based on review of PCCF's Searches Lesson Plan that indicated, "The purpose of the Lesson Plan is to teach staff how to conduct proper clothed and unclothed searches of detainees." The Lesson Plan's training objectives include the following: "1) demonstrate how to conduct a thorough cell search, 2) demonstrate how to perform a thorough pat or frisk search, 3) demonstrate how to conduct a thorough clothed and unclothed search, 4) review and recognize the criteria needed to perform an unclothed search of a pre-trial detainee, 5) demonstrate and explain how to be systematic, thorough, and objective when conducting searches, 6) determine whether contraband is present, 7) review procedures for inmate refusal, and 8) achieve a minimum score of 80% on a searches written exam." The Auditor reviewed training rosters indicating that 127 employees and contractors received training on searches within the past 12 months. The Training Supervisor reported that security staff are trained, through a combination of video, practical and lecture, on proper pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees. The Auditor interviewed five Correctional Officers and was informed they were trained on how to conduct pat-down searches. The Auditor asked two Correctional Officers specifically if they knew how to conduct a pat-down search of a transgender or intersex detainee, both stated they knew how to conduct a pat-down search of a transgender or intersex detainee through ongoing training. According to the lesson plan, staff who are conducting a clothed or unclothed search of a transgender or intersex detainee must notify their supervisor, escort the detainee to the medical area and request medical staff's assistance, if necessary.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The Auditor reviewed SOP 1105 (Special Needs Inmates/Detainees Identification). The policy states, "PCCF will ensure that inmates/detainees with special needs (deaf, hard of hearing, limited reading skills, blind or low vision) will be provided with a counselor to assist with reading and assistance with communication. An UltraTech Communications (TTY) system is available." In addition, SOP 1517 and the PCCF Detainee Handbook, state "A detainee with disabilities is provided with a counselor to assist with communications and that text telephone (TTY) is available for detainees who are deaf or hard of hearing; detainees with the above disabilities or challenges must submit a request for assistance to their housing unit counselor." The Classification Coordinator, the Behavioral Health Director and the Regional Medical Director were interviewed and indicated that sexual abuse information videos, PCCF Detainee Handbooks (English and Spanish), ICE National Detainee Handbooks, interpreter services, translation services, and staff interpreters are used to assist detainees who are deaf or hard of hearing, LEP, blind or low vision, have intellectual, psychiatric, or speech disabilities, and limited reading skills. The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The Auditor observed ICE zero-tolerance posters written in English and Spanish indicating the PSA Compliance Manager's name on housing unit bulletin boards and ERO Language Services posted for detainees to request translation or transcription services. The DHS-prescribed ICE Sexual Abuse Awareness Information postage is available in English and Spanish and Sexual Abuse Assault and Prevention Program (SAAPI) pamphlets were provided to the detainees upon intake. The intake staff could not explain how the detainees would receive the pamphlet in the other seven languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, which are also available by the agency. Also, the Classification Coordinator informed the auditor that if the detainee's language was not available in written materials, she and intake staff would utilize interpreter services to provide sexual abuse prevention information to the detainee during intake. Detainees who are blind or who have low vision are provided individualized services by medical staff or the Classification Coordinator to include reading information to the detainee if needed. The Warden advised that PCCF's detainees are provided several accommodations to assist with disabilities such as: TTY machine, extended visitation time and video conferencing, medical staff in-person assistance, and interpreter services. Of the 12 detainee files reviewed by the Auditor, 8 of the files indicated that the detainee was English speaking; however, interviews with the

corresponding 8 detainees, indicated that 5 the detainees interviewed preferred language was other than English. This was confirmed by the Auditor having to use interpretative services to effectively conduct interviews with all eight detainees.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. Intake staff, during their interviews, did not know how to access the DHS-prescribed Sexual Assault Awareness pamphlet in languages other than English and Spanish. In addition, although policy and staff interviews reflect that LEP detainees are provided zero-tolerance information, the Auditor was unable to confirm compliance. The Auditor interviewed and conducted file reviews of 12 detainees. Although, eight of the files indicated that the detainee was English speaking, interviews with the corresponding eight detainees, during which the Auditor had to use interpretative services to effectively communicate with them, indicated that five of the detainees interviewed preferred language was other than English. As five detainee files did not accurately reflect their preferred language, the Auditor could not determine that the detainees were provided meaningful access to the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse in a manner that they could understand. To confirm compliance, the facility must develop a practice that includes providing the detainee with all aspects of the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse, including, but not limited to, providing the detainee with a copy of the DHS-prescribed ICE Sexual Awareness Information pamphlet, in their preferred language. In addition, the Auditor requires the facility to train all applicable staff on the new procedure and to provide documentation of such training. The facility must also provide the Auditor with 10 detainee files of detainees who arrived on different days, and are not proficient in English or Spanish, confirming that the detainees have received all the aspects of the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse, including, but not limited to, providing the detainee with a copy of the DHS-prescribed ICE Sexual Awareness Information pamphlet.

(c): The Auditor determined compliance based on review of SOP 1517 which states that the "facility shall not rely on detainee interpreters except in exigent circumstances and where an extended delay in obtaining an effective interpreter could compromise the detainee's safety or the investigation" into the detainee's allegation. SOP 1105 (Special Needs Inmates/Detainees Identification) states, "PCCF will ensure that inmates/detainees with special needs (deaf, hard of hearing, limited reading skills, blind or low vision) will be provided with a counselor to assist with reading and assistance with communication. An UltraTech Communications system is available." The Auditor interviewed five Correctional Officers who informed they had communicated with LEP detainees by utilizing a bilingual dictionary, Google Translate, bilingual staff, or the facility's language line.

Recommendation (c): The Auditor recommends SOP 1105 be updated to mandate the use of in-person or telephonic interpretation services in situations pertaining to allegations of sexual abuse, and that other detainees are not used to provide interpreter services unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy.

§115.17 Hiring and promotion decisions.

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

Notes:

(a)(b)(e)(f): The Federal Statue 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 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." The ICE Personnel Security and Suitability Program 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. SOP 1517, states, "PCCF will not hire, promote or contract with anyone (that will have contact with detainees) who has engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in a prison, jail, lock up, community confinement facility, juvenile facility, or other institution or been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse. The PCCF will conduct criminal background checks, conduct a check of the state's child abuse registry, and make its best efforts to contact prior institutional employers to obtain this information on substantiated allegations of sexual abuse, or any resignations during a pending investigation of an allegation of sexual abuse." During interviews with the Assistant Warden and Human Resources staff it was confirmed that PCCF prohibits the hiring and promotions of anyone who may have contact with detainees and does not enlist the services of volunteers and contractors who have engaged in sexual abuse in prison, jail, holding facility, community confinement facility, juvenile facility, or other institution who has or attempted to engage in sexual abuse. The Human Resources staff and the Assistant Warden also indicated contractors or volunteers who have engaged in sexual abuse are prohibited from working at PCCF. The Assistant Warden further indicated during his interview that he would, within the allowance of law, provide information to a requesting facility on a previous PCCF employee whose investigation of sexual abuse was substantiated. The Human Resources staff, the Assistant Warden, and PCCF's job application packet requests applicants' signature to acknowledge their integrity and that any omissions in the job application may be grounds for withdrawal or termination. The Auditor reviewed PCCF's Employment PREA Questionnaire which indicates that all applicants are asked the required questions described in section (a) of this standard. In addition, the Auditor reviewed a logbook on-site that confirmed that PCCF staff received an initial background check

prior to being hired. Also, within the requested list of employee background requests, there were two employees who were promoted to sergeant and lieutenant; both received a background check upon their promotion.

(c)(d): During a training session in November 2021, and the training documentation available on SharePoint, the Unit Chief of OPR PSO explained that all ICE staff having contact with detainees must clear a background investigation through PSU before hiring. The staff complete an Electronic Questionnaire for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE. In addition, SOP 302 (Selection and Hiring) indicates that "the hiring process includes conducting a criminal background check through Pennsylvania Justice Network (JNET), a statewide database used by Pennsylvania state law enforcement agencies to collect criminal background information, and the National Crime Information Center, a national computerized index of criminal information used by federal, state, and local law enforcement agencies." The Auditor also reviewed SOP 2401 (Citizen Involvement/Volunteers) that states, "Background investigations are conducted on all volunteers prior to onboarding to determine their eligibility." The Human Resources staff and the Assistant Warden verified that background investigations are conducted on all job applicants prior to their job interview at PCCF. The Assistant Warden and the Human Resources staff indicated that background investigations are conducted on contractors who may have contact with detainees prior to their assignment. The Auditor reviewed the personnel record of one contractor and confirmed a background check was conducted. According to the Assistant Warden, JNET provides ongoing alerts of staff who have been entered into the system for an arrest, fine, driver's license suspension, and any other violation of the law. He also reported that a driver's license check is conducted on each staff annually to ensure staff does not have any of the above violations. The Auditor observed that the Assistant Warden keeps a record of the annual checks in a logbook.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): These subparts of the standard are not applicable based on the facility PAQ and interview with the Warden and PSA Compliance Manager confirming PCCF has not expanded or modified the existing facility or updated video monitoring equipment since 2005.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): The Auditor determined compliance with this subpart of the standard based on review of SOP 1517 that states, "The facility is responsible for investigating allegations of sexual abuse and sexual harassment. All allegations will be investigated promptly, thoroughly, and objectively by facility investigators who received special training in sexual abuse investigations in confinement settings." The policy includes a uniform evidence protocol that requires "The facility investigators will gather and preserve direct and circumstantial evidence, including any physical DNA evidence and any available electronic monitoring data" and "If criminal activity is determined by the facility investigator, the Pennsylvania State Police (PSP) will be contacted." The PSA Compliance Manager confirmed PCCF's uniform evidence collection protocol and advised there are no juveniles housed at PCCF. The Auditor reviewed two sexual abuse investigations conducted at PCCF within the past 12 months and determined that a uniform evidence protocol ensures preservation of evidence. A review of the protocol, in conjunction with staff interviews could not confirm that the protocol was developed in coordination with DHS. The Agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, "when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE Enforcement and Removal Operations, ERO Field Office Director (FOD), and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of the Inspector General (OIG), OPR, or the local law enforcement agency, the ICE AFOD would assign an administrative investigation to be conducted."

Does Not Meet (a): The facility does not meet standard 115.21 (a). The subsection requires that the protocol be developed in coordination with DHS. To become compliant the facility must forward their investigative protocol to DHS for review and approval.

(b): The Auditor determined compliance with this subpart of the standard based on review of SOP 1517 that states, "If of a criminal nature, the case will be forwarded to PSP; victim advocates are made available by Victims' Intervention Program (VIP) to accompany the detainee victim during sexual assault examination and interviews and to provide emotional support services." The Auditor reviewed PCCF's memorandum of understanding (MOU) with VIP, entered on 11/04/21, allowing VIP to provide advocacy and confidential support services to detainee sexual assault victims while at the hospital and during a forensic examination. The PSA Compliance Manager reported that VIP in Wayne and Clay Counties provide emotional support services to PCCF's detainee victims of sexual abuse. The Auditor observed VIP service and contact information on flyers located on the housing unit bulletin boards and on detainee tablets.

(c): The Auditor determined compliance with this subpart of the standard based on review of SOP 1517 which requires, "Medical to coordinate with the Shift Commander to arrange for a transport to Wayne Memorial Hospital for forensic medical examinations without cost to the detainee. Treatment services will be provided regardless of whether the victim names the abuser or cooperates with any

investigation arising out of the incident. Exams should be performed by sexual assault forensic examiners (SAFE's) or sexual assault nurse examiners (SANE's). In the event a SAFE or SANE is not available, a qualified medical practitioner will conduct the exam and staff will document on an incident report." The Vice President of PrimeCare and the Regional Medical Director confirmed the facility does not have a qualified staff person to conduct sexual assault examinations therefore detainees will be transported to Wayne Memorial Hospital or Pocono Medical Center for SANEs or SAFEs to conduct sexual assault examinations. The PSA Compliance Manager reported that there were no detainee victims of sexual abuse transported to the hospital for a forensic sexual abuse examination within the past 12 months. In addition, the Auditor conducted two staff-on-detainee sexual abuse investigative file reviews; neither of the allegations required the need for detainees to be transported to the hospital for sexual assault examinations.

(d): The Auditor determined compliance with this subpart of the standard based on review of PCCF's MOU with VIP, entered on 11/04/21, which allows VIP to provide advocacy and confidential support services to detainee sexual assault victims while at the hospital and during a forensic examination. The PSA Compliance Manager advised that the Shift Commander or medical will contact VIP to refer detainee victims of sexual abuse for emotional support services.

(e): The Auditor reviewed SOP 1517 and found no indication of PCCF requesting, or attempting to request PSP, to follow the requirements of paragraphs (a) through (d) of this section. The PSA Compliance Manager confirmed during the interview that PSP investigates all PCCF's criminal investigations of sexual abuse. The auditor was provided with and reviewed a memorandum (dated 12/17/21) written by the PSA Compliance Manager confirming that PSP conducts all PCCF criminal investigations into sexual abuse. This memorandum was signed by PSP lieutenant.

Does Not Meet (e): The Auditor was unable to confirm compliance with this subpart of the standard. The facility did not provide the Auditor with documentation confirming that the facility requested or attempted to request PCP to follow the requirements of paragraphs (a) through (d) of subsection (e) of the standard. To confirm compliance, the auditor recommends the facility request a detailed memorandum of understanding between PCCF and PSP addressing the requirements of subparts (a) through (e).

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): The Auditor determined compliance with the subparts of the standard based on review of Agency policy 11062.2 Sexual Abuse and Assault Prevention and Intervention, section 5.7, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (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. The JIC shall notify the DHS Office of Inspector General (OIG)." In addition, SOP 1517 that states, "The Warden, PSA Compliance Manager, or designee will contact PSP to conduct an official investigation into sexual abuse, notify the Field Office Director, notify ICE Supervisory Detention and Deportation Officer (SDDO) and the SDDO will notify the OPR. All written documentation pertaining to sexual abuse and sexual harassment investigations are retained for at least five years as long as the alleged abuser is incarcerated or employed by the agency plus an additional five years." A memorandum (dated 12/17/21) from the PSA Compliance Manager indicated that the PSP conducts PCCF's criminal investigations into sexual abuse. The PCCF Detainee Handbook indicated the facility's investigative protocol. The PSA Compliance Manager confirmed that PCCF would provide the agency with all collected information pertaining to the sexual abuse allegation to assist with the agency's investigation. The Warden verified that the facility provides the ICE Field Office with collected information pertaining to the sexual abuse allegation received. The Warden stated the PSA Compliance Manager and Assistant Warden sends an email to the assigned ICE Field Office. The Auditor reviewed the mass email generated notifying the ICE Field Office on a sexual abuse allegation received by the facility and confirmed compliance. The PSA Compliance Manager reported that all allegations into sexual abuse begin administratively and are referred to the PSP if there is a criminal component and indicated that PCCF posts its protocols on the facility's website at www.pikepa.org. The Auditor reviewed PCCF's website which included the facility's zero-tolerance policy and reporting procedures; however, the website did not indicate the facility's protocol to ensure that each allegation of sexual abuse is investigated by the agency or facility or referred to an appropriate investigative authority. The Auditor reviewed the ICE website, (https://www.ice.gov/prea), which provided the required Agency protocol.

Does Not Meet (c): The Auditor was unable to confirm compliance with this subpart of the standard as the facility's website does not include PCCF's investigation protocols. To confirm compliance, the facility must indicate PCCF's protocol on its website, or otherwise make the protocol available to the public, ensure that each allegation of sexual abuse is investigated by the agency or facility and/or referred to an appropriate investigative authority.

(d)(e)(f): The Auditor determined compliance with the subparts of the standard based on review of SOP 1517 that states, "PCCF protocol entails all allegations are promptly reported to the PSP to conduct an official investigation into sexual abuse (potential criminal), the Field Office Director (FOD), the ICE SDDO and the SDDO will notify the OPR." The PSA Compliance Manager confirmed that sexual abuse allegations are reported to PSP and the ICE Field Office and that the ICE Field Office reports to OPR and all required

DHS departments. The Auditor reviewed two investigative files of staff-on-detainee sexual abuse allegations reported at PCCF within the past 12 months. Neither allegation was determined to be criminal in nature; and therefore, the allegations were not reported to PSP. The file reviews further indicated that in both allegations of sexual abuse, PCCF reported the incidents to the SDDO. The Auditor briefly interviewed the SDDO prior to the audit closeout and was informed that he had promptly received all PCCF's allegations of sexual abuse through email from the PSA Compliance Manager and Assistant Warden. The SDDO confirmed upon receipt of a sexual abuse allegation from PCCF, he immediately notifies the JIC and the PSA Coordinator. The auditor reviewed and confirmed the email notification made to the ICE Field Office indicating an allegation of staff-on-detainee had been received. The Auditor reviewed two memoranda (dated 11/16/21 and 11/19/21) from PSA Compliance Manager that stated there were no instances of detainee-on-detainee sexual abuse, and there were no allegations of sexual abuse referred to the PSP within the past 12 months.

§115.31 - Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): SOP 1517 states, "PREA, sexual abuse and harassment are covered at least twice a year during shift briefings." The Auditor was provided with the Correctional Officers' Basic Training Lesson Plan on Inmate Sexual Assaults, Sexual Assaults Prevention/Intervention, and during the Auditor's review, it was found that the Lesson Plan belongs to Kansas Department of Corrections. The Training Supervisor reported that all facility staff who have contact with detainees receive training on PCCF's zero-tolerance policy, definitions pertaining to sexual abuse, recognition of situations where sexual abuse may occur, how to avoid inappropriate relationships with detainees, and effective communication with lesbian, gay, bisexual, transgender, and intersex (LGBTI) detainees; however, upon review by the Auditor, it was determined the lesson plan on Inmate Sexual Assaults, Sexual Assault Prevention/Intervention did not reflect effective communications with LGBTI detainees. The Auditor also observed that the lesson plan's objectives did not include PCCF's zero-tolerance policy, sexual assault, and prevention to reflect the actual dynamics of sexual abuse at PCCF, a detainee's right to be free from sexual abuse, and a detainee and staff's right to be free from retaliation for reporting sexual abuse. The Training Supervisor advised that he will conduct research to obtain a Lesson Plan that would address effective communication with LGBTI detainees. Five Correctional Officers were interviewed and confirmed they had received training on PCCF's zero-tolerance policy, sexual abuse prevention, reporting mechanisms, and response. The officers indicated their training did not include effective communication techniques with LGBTI detainees. Prior to the audit closeout, the Training Supervisor presented the Auditor with a Lesson Plan addressing effective communication with LGBTI detainees in confinement settings. The Auditor reviewed and confirmed that the Lesson Plan would provide PCCF's staff with the training needed. The Training Supervisor advised that the Lesson Plan would be included in the staff's training curriculum. The Auditor reviewed training reports/rosters confirming 225 employees had received PREA and Sexual Misconduct Training within the past 12 months including, but not limited to, "Lock Up USA Complying with PREA for the C.O," which included the facility's zero-tolerance policy, definition and examples of prohibited and illegal sexual behavior, recognition of situations where sexual abuse may occur, recognition of physical, behavioral, avoiding inappropriate behavior, and emotional signs of sexual abuse, reporting procedures, and preventing and response mechanisms." received during roll call on all three shifts. A review of additional training records of 11 employees acknowledged receipt of PREA and Sexual Awareness training within the past 12 months. However, the training does not address a detainee's right to be free from sexual abuse, or a detainee and staff's right to be free from retaliation for reporting sexual abuse. The Training Supervisor, along with the Auditor's review of 11 employee training records, confirmed that all facility staff who have contact with detainees receive refresher training on sexual abuse prevention and response twice a year. Five Correctional Officers were interviewed, and when asked, four of them stated that they received refresher training throughout the year. The other Correctional Officer reported he was a new employee.

Does Not Meet (a): Although the facility ensures staff are trained on PCCF's zero-tolerance policy, sexual abuse prevention, reporting mechanisms, and response, the facility was unable to provide the Auditor with sufficient documentation to determine compliance with all training requirements for this subpart. To confirm compliance, the Auditor recommends the Training Supervisor develop PCCF's own Lesson Plan addressing detainee sexual assault and prevention to reflect the actual dynamics of sexual abuse at PCCF, a detainee's right to be free from sexual abuse, and a detainee and staff's right to be free from retaliation for reporting sexual abuse. The Auditor also recommends the Training Supervisor include information regarding how to effectively communicate with LGBTI detainees. In addition, the facility must document that staff have received the added training as required by the standard.

§115.32 - Other training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): SOP 2401 (Citizen Involvement/Volunteers) states, "Volunteers must complete orientation and training program prior to their assignment." In addition, SOP 1517 states, "Prime Care medical staff are trained on the agency's zero tolerance policy, their responsibilities on prevention, detection, intervention, response, and reporting." Currently, PrimeCare staff are the only contractors who have recurring contact with detainees. However, should there be additional contractors assigned to work at PCCF, the above policy would not address those contractors. PCCF Volunteer Orientation Receipt forms were provided to reflect approximately 45 volunteers had received sexual abuse prevention, detection, and response training. The Auditor interviewed three medical contractors (the Vice President of PrimeCare, the Regional Medical Director and the Behavioral Health Director) and confirmed themselves, and their staff, had received annual PREA training on the facility's zero-tolerance policy. The Auditor confirmed contractor training through training reports/rosters that were reviewed.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. The facility's practice does not include providing training to other contractors who have contact with detainees on their responsibilities under the Agency's

and the facility's sexual abuse prevention, detection, intervention and response policies and procedures based on the services they provide. In addition, the facility's practice does not require that the facility document that the contractor received the training as required by the standard. In addition, during interviews, staff could not confirm compliance with training other contractors. To become compliant with subsections (a) and (b) of the standard, the facility must update their practice to include other contractors and provide the Auditor with confirmation of such change. In addition, if applicable, the facility must provide the Auditor with documentation that all other contractors have been trained on their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention, and response procedures, including the Agency's and facility's zero-tolerance policies regarding sexual abuse and information on how to report such incidents. The training must be documented as required by subsection (c) of the standard.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): The Auditor reviewed SOP 1517, which states that "detainees are provided information on prevention, intervention, self-protection, reporting, treatment, access to outside victim advocate or rape crisis center, and counseling during the intake process." The ICE National Detainee Handbook, available in English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese; the PCCF Detainee Handbook available in English and Spanish; and the DHS-prescribed Sexual Abuse and Assault Prevention Intervention (SAAPI) pamphlet, all provide detainees with information pertaining to the facility's zero-tolerance policy, prevention and intervention strategies, definitions of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and reporting mechanisms to include reporting to staff and the OIG. In addition, the ICE National Detainee Handbook states, "No one can retaliate against you for reporting sexual abuse or assault, participating in an investigation about sexual abuse or assault, or participating in sexual activity as a result of force, coercion, threats, or fear of force." The SAAPI pamphlet informs detainees how to protect themselves from sexual abuse by not being afraid to say "NO," engaging in positive programs, expressing safety concerns or fears with a trusted staff member, trusting their instincts to remove themselves from an uncomfortable situation. According to the ICE Detainee Handbook, detainees are informed of the importance of receiving and participating in immediate medical treatment as well as their entitlement to ongoing medical care as needed. The Classification Coordinator stated that the orientation program on sexual abuse prevention and PCCF's zero-tolerance policy are provided through video and the PCCF Detainee Handbook. The Auditor observed that the video transcript was based on a PowerPoint presentation provided to detainees in English and Spanish which states that a detainee may report sexual harassment or sexual abuse to a housing unit officer, Shift Commander, counselor, nurse, write a letter to the U.S. Marshal Service or OIG, or file an emergency grievance; the PowerPoint also states that victims of sexual abuse will be provided immediate and ongoing access to medical and mental health treatment and support services. According to the PowerPoint presentation, consensual and nonconsensual sexual activities are prohibited. The Classification Coordinator also stated that if the detainee's language was not available in written materials, she and her staff would utilize interpreter services to provide sexual abuse prevention information to detainees. Detainees who are blind or who have low vision are provided individualized services by medical staff or the Classification Coordinator to include reading information to the detainee if needed. The Warden advised that PCCF's detainees are provided several accommodations to assist with disabilities such as: Ultratech communications system (TTY), extended visitation time and video conferencing, medical staff in-person assistance, and interpreter services to ensure detainees receive information on the facility's prevention, detection, and response protocols pertaining to sexual abuse. The Auditor observed ICE Interpreter information flyers posted on the bulletin boards located on the housing units. In addition, The Auditor observed DHS-prescribed sexual assault awareness notices (English and Spanish), Consulate notices, the PSA Compliance Manager's name posted on the ICE sexual abuse notices (English and Spanish), and VIP notices (English and Spanish) on the housing unit bulletin boards, detainee tablets, and throughout the facility. The Classification Coordinator advised that if the detainee's language is not available at the facility, she and her staff utilize a tablet to direct the detainee to select his language and read the ICE National Detainee Handbook which is provided in 14 languages: English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese. However, although the DHS-prescribed SAA pamphlet is distributed in either English or Spanish during intake, the Intake staff could not explain how the detainees would receive the DHS prescribed SAAPI pamphlet in the other 7 languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. The Auditor conducted 10 detainee file reviews and confirmed that all detainees were provided the ICE National Detainee Handbook and DHS prescribed SAA pamphlets. There was no indication of detainees signing their orientation packet to acknowledge receipt. The Classification Coordinator advised due to the spread of COVID-19, detainees have not been signing orientation documents but that she documents detainees' receipt of orientation and places it in the detainee's file.

Does Not Meet (b): The Auditor was unable to determine compliance with this subpart of the standard. Although the facility provides the DHS prescribed SAA pamphlet to the detainees upon intake, the facility was unable to provide the Auditor with how the facility would locate and provide the aforementioned pamphlet in languages other than English and Spanish during intake. To become compliant, the facility must adapt the practice of providing the DHS-prescribed Sexual Awareness pamphlet to LEP detainees in a language they understand. Once developed, all Intake staff must receive documented training on the new procedures. In addition, the facility must provide the Auditor with copies of 10 detainee files in languages other than English and Spanish that document the detainee received the DHS-prescribed ICE Sexual Abuse and Awareness pamphlet in their preferred language.

§115.34 - Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The Auditor reviewed SOP 1517 that states, "All sexual abuse and sexual harassment allegations are to be conducted by PCCF staff assigned investigators who are specially trained on conducting investigations in confinement settings." The Auditor reviewed training certificates confirming the completion of specialized PREA investigative training for three facility investigators. The Training Supervisor verified that PCCF's assigned investigators have been specially trained to investigate sexual abuse in confinement settings, including him, although he doesn't conduct investigations. Also, during the Training Supervisor's interview, he provided the specialized training curriculum; the Auditor observed that the curriculum included techniques of investigating sexual abuse in confinement settings, Miranda and Garrity warnings, and evidence collection. The agency's Policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault training curriculum, which covers in-depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. The Auditor did not observe any policy or lesson plan addressing effective cross-agency coordination for facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities.

Does Not Meet (a): The Auditor was unable to determine compliance with this subpart of the standard. The facility provided specialized training to assigned sexual abuse investigators; however, there was no documentation supporting facility investigators received training on cross-agency coordination. To become compliant, the facility must update their lesson plan to reflect cross agency coordination as required by the standard and provide the Auditor with updated lesson plan. In addition, the facility must provide the Auditor with documentation that the facility investigator received training on the updated lesson plan.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The facility's Health Services are provided by PrimeCare, and not ICE Health Services Corps (IHSC). Therefore, subsections (a) and (b) are not applicable.

(c): The Auditor reviewed SOP 1517 that states, "Prime Care medical staff are trained in the following: 1) how to detect and assess signs of sexual abuse, 2) how to respond effectively and professionally to victims of sexual abuse, 3) how and to whom to report allegations or suspicions of sexual abuse, how to preserve physical evidence of sexual abuse." The Auditor interviewed three medical contractors (the Vice President of PrimeCare, the Regional Medical Director, and the Behavioral Health Director); when asked, the Regional Medical Director and the Behavioral Health Director explained that they receive specialized medical training on an annual basis through Relias training system. The Training Supervisor verified that medical and mental health staff at PCCF receive specialized medical training through Relias and training on the facility's zero-tolerance policy as do all other staff at PCCF. The Regional Medical Director and the Behavioral Health Director reported that PCCF medical staff do not conduct forensic sexual abuse examinations.

Does Not Meet (c): The Auditor was unable to determine compliance. The facility was unable to provide the Auditor with documentation indicating that the facility forwarded SOP 1517 to the Agency for review and approval. In addition, the facility could not document that Prime Care medical staff and/or mental health staff were trained as required by SOP 1517. To become compliant, the facility must provide the Auditor with confirmation that the policy was submitted to the Agency for review and approval. In addition, the facility must provide the curriculum used to provide specialized training as required by SOP 1517 and documentation that all PrimeCare medical and mental health staff are trained as required by SOP 1517.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The Auditor reviewed SOP 2002 (Classification/Orientation) that states, "The Classification Coordinator or designee will conduct an interview with all new intakes and complete the Classification Profile Worksheet in the Offender Management System." PCCF has a two-phase intake classification process. The first phase is conducted immediately upon intake and consists of a medical screening which is inclusive of the PREA initial assessment; this portion of the process is completed by medical staff. The second phase is conducted within three days of arrival and consists of the initial classification process, which is administered by the Classification Coordinator or designee. During interviews, the Classification Coordinator, the Regional Medical Director, and the Behavioral Health Director reported that PREA assessments are conducted by medical staff during intake to determine detainees' risk for sexual victimization or sexual abusiveness and that detainees are kept separate from general population until classification is completed. The Classification Coordinator indicated that detainees who have not been classified are housed with detainees who have been classified but that they are kept separate. The PSA Compliance Manager reported that detainees are housed in the Classification Unit during the initial classification process on level one, level two, level three, or even restrictive housing. The Auditor verified the classification point system by review of 14 detainee's classification records; however only one file contained documentation that confirmed that a detainee

had undergone an initial classification within 12 hours of admission. Seven detainees reported during their interviews that they had an initial PREA assessment with medical; however, there were some inconsistencies with the amount of time they were in the intake area. The classification records included the detainee's booking date but did not include the actual time of admission. Two of the detainees reported they were in intake for one to four days. The Classification Coordinator stated that detainees are given a three-day observational period prior to initial classification.

Does Not Meet (a)(b): Interviews with classification staff indicated that unclassified detainees are housed with detainees who are classified and that detainees are given a three-day observational period prior to initial classification and housing, which is inconsistent with subsection (a) of the standard that requires that the facility assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims, and, the requirement to keep separate all detainee new arrivals from the general population until he/she is classified and may be housed accordingly. In addition, the Auditor's review of 14 detainee records, with the exception of one file, could not confirm the initial classification and housing was completed within 12 hours as required by subsection (b) of the standard. To confirm compliance with subsections (a) and (b) of the standard, the facility needs to create, and implement, a practice which ensures the initial risk screening/classification process/housing assignment is completed within 12 hours and that arrivals are separated from general population until classified accordingly. In addition, the facility must provide 10 detainee files that clearly indicate that PCCF completed the initial risk screening on intake, the classification and housing assignment process within 12 hours, and detainees were kept separated from the general population.

Recommendation: The Auditor recommends that the facility update SOP 2002 to detail the initial screening process and that the initial intake screening process, including classification and an initial housing assignment, will be completed within 12 hours as required by the standard.

(c)(d): SOP 2002 states, "The Classification Coordinator or designee will conduct an interview with all new intakes and complete the Classification Profile Worksheet in the Offender Management System." The auditor observed that the Classification Profile Worksheet is objective and considers whether the detainee has a mental, physical, or developmental disability, the detainee's age, the detainee's incarceration history, criminal history, history of sexual victimization, history of violent offenses, prior institutional violence or sexual abuse, sex abuse offenses, and whether the detainee identifies as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming. However, the screening form does not address the detainee's physical build or the detainee's own concerns about his/her safety, nor is this information asked elsewhere during the intake process.

Does Not Meet (c): The facility conducts initial assessments using an objective screening tool, the Classification Worksheet; however, the screening tool does not include the detainee's physical build and appearance or the detainee's own concerns about his/her safety, nor is it asked elsewhere during the intake process. To confirm compliance, the facility must adjust their process to ensure the detainees physical build and appearance and the detainee's own concerns about his/her safety as required by paragraphs (3) and (9) of subsection (c) of the standard are included in the screening.

(e)(f)(g): The Auditor reviewed SOP 2002 that states, "A 60–90-day re-classification is conducted by the Classification Coordinator or designee after the initial classification assessment and when a detainee's behavior reflects the need to be classified." The Auditor also reviewed SOP 1517 that states, "Staff is prohibited from revealing information pertaining to sexual abuse to anyone other than to the extent necessary." The Classification Coordinator confirmed that she and intake staff conduct detainee classification reassessments within the first 30 days, and 60–90-day intervals. The Auditor reviewed 14 detainee files and confirmed that only one detainee was due for a 60–90-day re-classification as required by the standard. A review of the classification document confirmed the re-assessment was completed within the 60–90-day timeframe as required. The PSA Compliance Manager verified that the Classification Coordinator completes the classification reassessments. However, there was no documentation in the detainee victims' files indicating that a reassessment was completed after an incident of sexual abuse. The Classification Coordinator, and the PSA Compliance Manager indicated that detainees are not punished for refusing to answer assessment questions during intake. Also, the Classification Coordinator indicated that sexual abuse risk assessment information is kept in the Offender Management System (OMS) and that only intake staff have access to the information. The PSA Compliance Manager verified PCCF's policy indicating that sexual abuse information is disseminated on a need-to-know basis.

Does Not Meet (e): The facility does not meet subsection (e) of the standard. A review of the two investigative files did not confirm that a reassessment had been completed following the incident of sexual abuse as required by the standard. To confirm compliance, the facility must update their process to ensure that a reassessment is completed at any time when warranted based upon the receipt of additional relevant information or following an incident of sexual abuse or victimization. In addition, the facility must document that all Classification staff are trained on the new procedure. The facility must provide to the Auditor, if applicable, all investigative files of allegations that occurred during the CAP period and the related risk assessments.

Recommendation: The Auditor recommends that the facility updates SOP 2002 to include that a reassessment will be completed on detainees following an incident of sexual abuse or victimization and/or after receipt of additional, relevant information.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on interviews with staff and documentation provided. The PSA Compliance Manager indicated that staff makes individualized assessments for housing and classification decisions by asking specific screening questions during intake: mental, physical, or developmental disability; age of the detainee; detainee's previous incarceration; nature of the detainee's criminal history; detainee's convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; and if the detainee has self-identified as having previously experienced sexual victimization; however, the Auditor could not confirm through detainee file reviews or in interviews with the Classification Coordinator that the information from the risk screening is used in determining recreation and other activities or voluntary work assignments. The Classification Coordinator indicated that transgender or intersex detainees are given the opportunity to shower separately from other detainees. The Auditor reviewed a memorandum (dated 11/16/21) from the PSA Compliance Manager indicating there were no transgender or intersex detainees admitted into the facility within the past 12 months. Five Correctional Officers were interviewed by the Auditor; three of the officers indicated that transgender and intersex detainees are provided the opportunity to shower separately and two were unsure of the process. The PSA Compliance Manager reported that all detainees shower alone during the initial assessment process and throughout their stay at PCCF.

Does Not Meet (a)(b): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41. The Auditor could not confirm through detainee file reviews or in an interview with the Classification Coordinator that the information from the risk screening (although, already noted in 115.41 is lacking necessary criteria to be a full risk screening) is used in determining recreation and other activities or voluntary work assignments. To become compliant with subsection (a) of the standard, the updated risk screening tool needs to be utilized so that detainee participation in recreation, volunteer programming and other activities can be properly assessed. In addition, all Intake and applicable staff should be trained in the proper use of the risk screening form when determining the elements of the standard. The facility must provide the Auditor with 10 detainee files to document that the risk screening was considered when determining recreation, programming, and volunteer work. Furthermore, the facility is not in compliance with section (b) of the standard. Although the facility conducts an initial PREA screening upon intake, the facility was unable to demonstrate, through an interview with the Classification Coordinator, that the information or documentation pertaining to housing decision, recreation, and programming of transgender or intersex detainees t are parallel to that of a detainee in general population. In addition, the facility was unable to provide the Auditor with documentation pertaining to the reassessments of transgender or intersex detainees. To become compliant, the facility must update their procedure to include when making assessment and housing decisions for a transgender or intersex detainee, the facility must consider the detainee's gender, self-identification, and an assessment of the effects of placement on the detainee's health and safety. In addition, the facility must include that a transgender or intersex detainee's housing recreation, and programming decisions are reviewed at least twice a year to determining if any threats to safety were experienced by the detainee. If applicable, the facility must provide the Auditor with any transgender, or intersex detainee files and medical records to determine compliance.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): The Auditor reviewed SOP 1101 (Administrative Segregation/Protective Custody) that states, "Involuntary segregated housing/protective custody shall not ordinarily exceed a 30-day period, however, if needed longer, a review will be provided every 30 days if such housing is ongoing or needed." Additionally, SOP 2002 states, "An inmate/detainee who has partially completed a gender change procedure will be placed in administrative segregation pending a review by the facility Doctor. If an inmate/detainee is found to have a mix of female and male genitalia, he/she will be classified max/protective custody for his/her protection. Any transgender inmate/detainee will be housed alone and will recreate alone." However, the policy does not address that transgender or intersex detainees having access to programs, visitation, or counsel. Likewise, neither policy address the use of administrative restrictive housing to protect detainees vulnerable to sexual abuse or sexual assault are restricted to those instances where reasonable efforts have been made to provide appropriate housing and must be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. A review of SOP 1101, in conjunction with the Warden and SDDO interviews, indicates that the policy has not been developed with the ICE ERO Field Office as required by subsection (a) of the standard. In addition, the policies do not describe how an individualized assessment would be made to determine appropriate housing prior to placing detainees into restrictive housing as a last resort of ensuring their sexual safety.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. The facility's SOP 1101 has not been developed in consultation with the ICE ERO Field Office. In addition, SOP 1101 indicates that detainees are sent to administrative restrictive housing or protective custody for no longer than 30 days and that a transgender or intersex detainee would be sent to protective custody automatically. The policy does not describe how an individualized assessment would be made to determine appropriate housing. To confirm compliance, the Auditor requires the facility, in consultation with the ICE ERO Field Office, to update SOP1101 and their practices to ensure individualized assessments are made to determine appropriate housing and to use administrative restrictive housing as a last resort. In addition, the facility, in conjunction with the ICE ERO Field Office, must update SOP 1101 to include that the transgender or intersex detainee will be housed in administrative segregation only after an individualized assessment to determine appropriate housing. In addition, if applicable, the facility must provide the Auditor with any transgender or intersex detainee files and medical records to document that the facility properly assessed the detainee prior to assigning the detainee

to administrative segregation. The facility is also not in compliance with subsection (c) of the standard. Facility SOP 1101 does not include the verbiage that a detainee in Administrative Segregation due to vulnerability to sexual abuse is afforded access to programs, visitation, counsel, and other services available to general population. To become compliant the facility, in conjunction with the ICE ERO Field Office, must include such verbiage in SOP 1101. The facility must also provide the Auditor with documentation that all applicable staff have been trained in the new policy/practice. In addition, if applicable the facility must provide the Auditor with any detainee's file who has been placed in administrative segregation due to being vulnerable to sexual abuse/assault and, if applicable, the facility must provide the Auditor with any transgender or intersex detainee files and medical records to document that the facility properly assessed the detainee prior to when before assigning the detainee to administrative segregation.

(d)(e): The Auditor reviewed of SOP 1101 which states, "The Shift Commander reviews the staff member's incident report pertaining to a detainee's need to be placed into protective custody and completes an administrative segregation form which is forwarded to the detainee within 24 hours. The Assistant Warden reviews all temporary administrative segregations within 72 hours." This policy states "if a detainee has been placed into protective custody, he/she will be afforded the opportunity to have a hearing conducted by the Classification Committee (Classification Coordinator, Shift Commander or designee, and a Treatment Counselor) concerning protective custody placement. Weekly reviews will be conducted by the Committee to determine the need for protective custody. The ICE SDDO will be notified when an ICE detainee's stay in administrative segregation has exceeded 30 days and will also receive a weekly update on all ICE detainees in administrative segregation." However, the standard requires the ICE FOD be notified within 72 hours after the initial placement into administrative segregation based on vulnerability to sexual abuse or assault. The Warden indicated that the facility would notify the ICE Field Office immediately and that protective custody starts at booking depending on the outcome of the PREA intake screening. The auditor reviewed a memorandum (dated 12/19/21) from the PSA Compliance Manager informing there was no detainee placed in protective custody within the past 12 months. According to 10 detainee file reviews, there were no detainees housed in protective custody due to a sexual abuse vulnerability.

Does Not Meet (d)(e): According to SOP 1101, detainees who are placed into protective custody or administrative segregation are afforded the opportunity to have a hearing conducted by the Classification Committee and that such reviews by this Committee will be conducted on a weekly basis. However, subsection (d) of the standard requires that a supervisor conduct, at a minimum, a subsequent review after the detainee has spent seven days in administrative restrictive housing, and every week thereafter for the first 30 days, and every 10 days thereafter. In addition, the policy is not consistent with addressing who is responsible for the subsequent reviews (the Assistant Warden or the Classification Committee) and when such reviews are conducted. Therefore, to become compliant with this subsection of the standard, the facility must update its policy to provide specified timeframes of subsequent reviews and clearly indicate who is responsible for conducting the reviews. Facility policy dictates that the facility notifies the ICE SDDO when an ICE detainee's stay in administrative segregation has exceeded 30 days; however, subsection (e) of the standard requires the ICE FOD be notified within 72 hours after the initial placement into administrative segregation based on vulnerability to sexual abuse or assault. To become compliant the facility must update SPO 1102 to require the facility to notify ICE SDDO within 72 hours after the detainee's initial placement into administrative segregation based on vulnerability to sexual abuse or assault and that the SDDO notifies the FOD within the 72-hour timeframe as required by the standard. In addition, the facility must document that applicable staff have been trained in the updated SOP. Further, if applicable, the facility is to submit confirmation that the ICE FOD had been notified within 72 hours of the detainee being placed in administrative segregation because of being vulnerable to sexual abuse or assault.

§115.51 - Detainee reporting.

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

Notes:

(a)(b)(c): SOP 1517 states, "Detainees may report sexual abuse or sexual harassment to any staff member or PrimeCare Medical staff, by filing a grievance through the detainee tablets, by filing an emergency grievance, by writing the U.S. Marshal Services or Office of Inspector General, and by calling VIP." Also, SOP 1517 states, "Staff has a responsibility to follow up once a report is made verbally or in writing." During his interview, the PSA Compliance Manager confirmed the many ways detainees can report an incident of sexual abuse at PCCF. The auditor observed English and Spanish DHS signage on the housing unit bulletin boards indicating toll free phone numbers for the Sexual Abuse Hotline, DHS OIG, VIP, as well as consulate information. ICE zero-tolerance flyers indicating the PSA Compliance Manager's name were posted in English and Spanish on the housing unit bulletin boards throughout the facility. During the onsite audit, the Auditor contacted the ICE Detention Reporting and Information Line (DRIL) and determined the line was not anonymous as detainee's were required to give a PIN number. Seven detainees interviewed reported they received additional sexual abuse information after intake. The Auditor also interviewed a detainee victim of sexual abuse and was informed he reported sexual abuse through the grievance system on the housing unit kiosk. There were two reported sexual abuse allegations at PCCF within the past 12 months. Both detainee victims reported the sexual abuse allegations through the grievance system on the housing unit kiosk.

Recommendation: The Auditor recommends that the facility update all documentation provided to the detainee, including but not limited to posters and the PCCF Detainee handbook, to reflect that the DRIL is not an anonymous method for the detainee to report an incident of sexual abuse.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): The Auditor reviewed SOP 1605 (Inmate/Detainee Grievances) which states, "Detainees may file a grievance related to sexual abuse." The PCCF Detainee Handbook indicates, "A detainee may file a complaint of sexual abuse by calling or writing the DHS OIG. A detainee who perceives an immediate threat to their health, safety or welfare may submit a sensitive or emergency grievance by submitting through housing unit kiosk or if in restrictive/segregated housing, the emergency grievance may be written and submitted directly to the Shift Commander. If the request does not receive a response within one hour, an alert is sent to the Warden and both Assistant Wardens. Detainees may submit a medical grievance through the housing unit kiosk but that detainees in restrictive housing may obtain a medical grievance form and envelope from the housing unit officer to submit a medical grievance. The Grievance Committee will respond to a detainee's grievance in writing within 10 business days of the date the grievance was received. A facility nurse will provide a written response pertaining to a medical grievance within five days of receipt. Detainees are provided assistance if needed when preparing for a grievance. Grievance preparation and submission assistance will be provided to detainees who are not fluent in English, need interpretive services, are disabled or those needing general assistance." The policy does not indicate that detainees are allowed to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging a formal complaint; that the facility must respond to a detainee's appeal of his/her grievance within 30 days; a detainee will be issued a decision on the grievance within five days of receipt; and that PCCF must send all grievances related to sexual abuse and the facility's decision with respect to such grievances to the appropriate ICE FOD at the end of the grievance process. According to the PCCF Detainee Handbook, "to obtain assistance, the detainee must use the housing kiosk or ask the housing unit counselor." SAAPI pamphlets and ICE Detainee Handbooks inform detainees of multiple ways to report sexual abuse which includes third-party and anonymous reporting. Five Correctional Officers were interviewed and when asked, four stated they would accept a sexual abuse report made through the grievance system and that the detainees use the kiosks on their housing units to submit grievances. Eight detainees confirmed they could report a sexual abuse allegation to any staff member, verbally and through the grievance system. While at PCCF, the Auditor initiated a "test" grievance through the kiosk to gather an understanding of PCCF's grievance system. The PSA Compliance Manager provided the Auditor with an email receipt specifying the date, time, offender, and brief synopsis of the "test" grievance. The email receipt also indicated that the grievance was sent to the Warden, Assistant Warden, and facility investigators. The Auditor reviewed two detainee investigative file reviews and did not observe any documentation supporting that the facility provided the detainee with a grievance response within five days.

Does Not Meet (a)(e): Although the facility's policy indicated that detainees may file a grievance relating to sexual abuse, PCCF was unable to provide supporting information permitting a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. SOP 1605 states that "the Grievance Committee responds to the detainee grievances in writing within 10 days;" however, the subpart of this standard requires the facility to provide a response to a grievance of sexual abuse within five days. Furthermore, review of the two detainee investigative files, both of which were initially reported to the facility through the grievance process, lacked documentation supporting a response within five days. Therefore, the Auditor is unable to determine compliance with this subpart of the standard. To confirm compliance, the facility must update policy and change its practice to reflect that a detainee will be issued a decision on the grievance within five days of receipt. In addition, SOP 1605 must be updated to include the verbiage that allows the detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging a formal complaint, the facility must respond to a detainee's appeal of his/her grievance within 30 days, and that PCCF must send all grievances related to sexual abuse and the facility's decision with respect to such grievances to the appropriate ICE FOD at the end of the grievance process.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d) The Auditor reviewed SOP 1517 and the PCCF Detainee Handbook indicating VIP is written into the facility's policies to provide detainee victims of sexual abuse with outside confidential support services. A review of SOP 1517 indicated "medical staff informs detainees, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." PCCF entered into a MOU with VIP on 11/04/21 which allows VIP to provide "certified crisis counselors, advocacy services, confidential support services, and accompaniment in court proceedings to detainee sexual assault victims." The Auditor observed VIP flyers, which included VIP address and telephone number, posted throughout the housing units. VIP information is in the PCCF Detainee Handbook but does not include an address or phone number. According to the PCCF Handbook, the VIP phone number and address are on detainee tablets. The PSA Compliance Manager reported that the facility informs detainees about VIP services through detainee tablets and flyers posted on the housing unit bulletin boards. The PSA Compliance Manager reported that PCCF contacts VIP to provide emotional support services to detainee victims of sexual abuse. During the onsite audit, the Auditor confirmed that the tablets contained the phone number and address of VIP but did not advise detainees of the extent to which such communications between detainees and VIP will be monitored and reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. In addition, the Auditor contacted VIP and confirmed that they would provide the services as required by the standard.

Does Not Meet (d): The Auditor was unable to confirm compliance with subpart (d). To confirm compliance, the Auditor recommends that the facility include in the PCCF handbook the extent to which such communications will be monitored, and to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Recommendation: The Auditor recommends that the facility include the address and phone number of VIP in the PCCF handbook and/or place on the tablet or post near the telephones.

§115.54 - Third-party reporting.

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

Notes:

The Auditor determined compliance with the standard based on review of SOP 1517 that states, "Third party (family, friends) may report sexual abuse on a detainee's behalf." The Auditor observed DHS OIG posters located on the housing unit bulletin boards and in the video conferencing room encouraging the public to report sexual abuse on behalf of a detainee. Also, the Auditor observed PCCF's website (pikepa.org) informing the public of the facility's zero-tolerance policy and sexual abuse reporting mechanisms and indicated a link to make a report. The auditor also reviewed the ICE website, www.ice.gov/prea, and confirmed it contained information on third party reporting. The Auditor reviewed 10 detainees' files and two investigative files and there was no indication of a sexual abuse allegation reported by a third-party within the past 12 months.

§115.61 - Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): The Auditor reviewed SOP 1517 that states, "Security staff are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in writing to the Shift Commander and non-security staff to immediately notify the Shift Commander and their Department Head immediately. Staff is prohibited from revealing information about sexual abuse to anyone other than to the extent necessary. If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws." Three Correctional Officers were asked during their interview when they would report an incident of sexual abuse. All three officers reported they would immediately report to the Shift Commander if they received a detainee's report of sexual abuse. The PSA Compliance Manager and the Warden verified that staff must immediately report sexual abuse. The Auditor confirmed through observation and staff interviews that there are no juveniles housed at PCCF. The Auditor could not confirm during interview the facility's obligation when a sexual abuse allegation involves a vulnerable adult.

Does Not Meet (a)(d): The facility is not in compliance with subsections (a)(d) of the standard. A review of facility SOP 1517, in conjunction with staff interviews, could not confirm that the facility provides staff with a method to which they can report an incident of sexual abuse outside the chain of command; and therefore, the facility is not in compliance with subsection (a) of the standard. In addition, interviews with staff could not confirm their awareness of how to report an allegation of sexual abuse as required under mandatory reporting laws, therefore, making the facility not compliant with subsection (d) of the standard. To become compliant with subsection (a) of the standard, the facility must update SOP 1517 to include a method to which staff can report an incident of sexual abuse outside the chain of command and document that all staff have been trained on the updated policy. To become compliant with subsection (d) of the standard, the facility must train all applicable staff on the Pennsylvania mandatory reporting laws and their obligation to report an incident of sexual abuse involving a vulnerable adult to the designated State of local agency. If applicable, the facility must submit documentation that the designated State or local agency under applicable mandatory reporting laws was contacted because of a vulnerable adult being the victim of a sexual abuse or assault.

§115.62 - Protection duties.

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

Notes:

The Auditor determined compliance with the standard based on review of SOP 1517 that allows "security staff to immediately separate the detainee victim from the abuser." The Warden, PSA Compliance Manager, Behavioral Health Director and Correctional Officers indicated if a detainee is known to be at risk of imminent sexual abuse, staff have the authority to remove the detainee from immediate danger and contact the Shift Commander. A review of the two closed investigation files indicated neither detainee was subject to a substantial risk of imminent sexual abuse.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d): PCCF SOP 1517 states, "Upon learning that a detainee had been sexually abused in another facility, the Warden of the facility in which the incident allegedly occurred would be notified within 72 hours. An incident report is generated to reflect notification made to another facility." The Auditor reviewed a memorandum (dated 11/16/21) from the PSA Compliance Manager stating there were no allegations of sexual abuse received from another confinement facility within the past 12 months. The PSA Compliance Manager indicated upon receiving notification that a detainee had been sexually abused while in another facility, the Warden would immediately notify the other facility's Warden or Administrator and the ICE Field Office. In addition, the Warden further confirmed if an allegation of sexual abuse was reported at PCCF, he would immediately report the incident to the other facility's administrator, notify the ICE Field Office, and immediately refer the allegation for investigation. A review of the two sexual abuse allegations confirmed that the incidents did not occur at a facility other than PCCF.

Recommendation: The Auditor recommends that SOP 1517 be updated to include the verbiage, "The Agency or facility office that receives such notification, shall ensure that the allegation is referred for investigation in accordance with the standards and reported to the appropriate ICE FOD" to mirror their practice of ensuring an investigation is conducted and the ICE FOD is notified.

§115.64 - Responder duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The Auditor reviewed SOP 1517 that states, "If security staff becomes aware of alleged sexual abuse, the detainee victim and abuser must be separated, immediately notify Shift Commander and medical, secure the crime scene, take photographs or video recordings of the scene, ensure the detainee victim does not shower, wash, brush teeth, urinate, defecate, drink, eat, or change clothing. Non-security staff first responders will ensure the detainee victim does not take any actions that could destroy physical evidence and notify the Shift Commander and their Department Head immediately." The Auditor reviewed a memorandum (dated 11/19/21) from the PSA Compliance Manager stating there were no allegations of sexual abuse received from a non-security first responder staff within the past 12 months. The Behavioral Health Director, PSA Compliance Manager, Training Supervisor, kitchen staff, and Correctional Officers indicated they were knowledgeable of their first responder duties. During the two investigative file reviews, the Auditor confirmed that one of the detainee victims was separated from the alleged staff perpetrator; however, there was no indication of such separation or any other first responder duties in the other investigative file.

Does Not Meet (a): The Auditor was unable to determine compliance with subsection (a) of the standard. The facility was unable to provide confirmation of the first responder duties completed in one of the sexual abuse allegations. To confirm compliance, the facility must provide documented refresher training regarding their responsibilities as first responders. In addition, if applicable, the facility must provide the Auditor with all investigation files that result from allegations of sexual abuse to confirm that staff are knowledgeable in their duties as first responders.

§115.65 - Coordinated response.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on review of SOP 1517 describing the institutional plan to coordinate actions taken by security and non-security staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to sexual abuse incidents. SOP 1517 further states, "If a detainee victim of sexual abuse is transferred to a DHS or non-DHS immigration detention facility, PCCF will notify the receiving facility of the incident and the detainee victim's need for medical treatment or social services, if permitted by law. When a sexual abuse allegation is made, the detainee victim is immediately removed from imminent danger. The Shift Commander is contacted along with medical staff. The Assistant Warden assigns the case to one of the specially trained facility investigators. The assigned investigator begins the administrative investigation and when determined to be criminal, the investigator, PSA Compliance Manager, or Assistant Warden refers the case to PSP for criminal investigation. The PSA Compliance Manager ensures all collected information is provided to PSP. PSP and/or medical staff contacts VIP if the detainee victim is sent to the hospital for SAFE/SANE examination." The Warden and PSA Compliance Manager confirmed this policy. The Auditor reviewed a memorandum (dated 11/16/21) from the PSA Compliance Manager stating there were no detainees transferred from PCCF to another facility who reported sexual abuse within the past 12 months. A review of the two investigation files further confirmed the detainee victims were not transferred to another facility due to reporting sexual abuse.

Recommendation: The Auditor recommends that SOP 1517 be updated to include that in non-DHS facilities, the information will be shared unless the victim requires otherwise, as observed through facility practice.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

The Auditor reviewed SOP 1517 that states, "An employee may be relieved of his/her duties if deemed necessary and that employee may be suspended pending the outcome of the investigation. Staff will be removed from all duties requiring detainee contact with detainees pending outcome of an investigation." The Warden and PSA Compliance Manager confirmed the detainee victim would be separated from the alleged staff perpetrator by removing staff from any contact with the detainee victim pending the outcome of investigation. However, the Auditor conducted two investigative file reviews of staff-on-detainee sexual abuse and found that only one staff was removed and prohibited from having any contact with the detainee victim pending outcome of the investigation. In addition, there was no supporting documentation or policy provided regarding detainee protection from contractor or volunteer perpetrators.

Does Not Meet: The Auditor was unable to determine compliance with this standard. In review of the two staff-on-detainee investigative files, only one file indicated staff had been removed from having contact with the detainee victim pending outcome of the investigation. In addition, the facility must demonstrate, if applicable that staff, volunteers, or contractors were removed from duties during the investigation process by providing the Auditor copies of investigation files that occurred during the CAP period. Finally, the facility must provide documented training of all applicable staff in the section of policy SOP 1517 that requires any staff suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of the investigation as determined by ICE.

Recommendation: The Auditor recommends that the facility include verbiage within their governing SOP regarding contractors and volunteers being removed from detainee contact pending the outcome of a sexual abuse allegations where they are the alleged perpetrator. In addition, the Auditor recommends that all applicable staff receive training on the updated SOP.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) The Auditor reviewed SOP 1517 that prohibits any retaliatory action against "any detainee victim of sexual harassment or sexual misconduct and against any staff who reports or cooperates with such investigation. Protection measures such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations." The policy also states, "The Assistant Wardens and Shift Commanders/Department Heads monitor to see if any changes may suggest retaliation and that such issues will be addressed during the weekly classification meeting by reviewing disciplinary reports, housing unit changes, and program changes. Staff is monitored by the Assistant Wardens in their staff performance appraisals and staff reassignments." In one section, policy states the Assistant Wardens and Shift Commanders are responsible for retaliation monitoring. However, in the investigations section, policy indicates the PSA Compliance Manager is responsible for retaliation monitoring for at least 90 days. The Auditor reviewed a memorandum (dated 01/27/21) from the PSA Compliance Manager stating that he completed a 90 day follow up with a detainee victim of sexual harassment and determined there was no indication of retaliation. The Warden indicated retaliation monitoring is conducted for at least 90-days, and "PCCF has a Special Needs Committee assigned to review housing issues, disciplinary, any other issues after reporting." In addition, the Warden indicated that he also follows up with the detainee victim to ensure there is no retaliation and advised that sometimes the PSA Compliance Manager is contacted during the Committee meetings for more information gathering. The Auditor conducted a file review of two sexual abuse allegations and neither file indicated 90-day retaliation monitoring was completed.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. The Auditor conducted a file review of two sexual abuse allegation and neither file confirmed that the required 90-day retaliation monitoring was completed. To confirm compliance, the facility must develop a process to ensure retaliation monitoring is conducted and documented as soon as an allegation is reported and must provide training to staff responsible for monitoring for retaliation. The facility must provide the process established, documented staff training, and examples of all retaliation monitoring completed during the CAP period (if available) for compliance review.

Recommendation: The Auditor recommends that the facility update SOP 1517 to be consistent in all sections as to who oversees retaliation monitoring.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on review of SOP 1517 that states, "Detainee victims of sexual abuse will be classified and reassigned to protective custody, away from general population." SOP 1101 states that "all detainees in administrative segregation for any reason shall go before the Classification Committee to review the detainee's status on a weekly basis. The PSA Compliance Manager stated a weekly reassessment is conducted before returning a detainee victim to general population." The Auditor reviewed a memorandum (dated 11/17/21) from the PSA Compliance Manager stating there were no detainees placed in restrictive housing for protection from sexual abuse within the past 12 months. The Auditor confirmed there were no detainees housed in protective custody after reporting sexual abuse through observation, detainee file reviews, and investigative file reviews. The PSA Compliance Manager indicated that should the facility determine the detainee victim of a sexual abuse allegation needs to be placed in protective custody, the facility will house the alleged sexual abuse victim in the intake area for no longer than five days. The PSA Compliance Manager indicated he would report to the appropriate ICE FOD whenever a detainee victim has been held in administrative segregation for 72 hours. The Warden verified the notification to the ICE FOD would be made immediately through email.

Recommendation: The SOP 1517 states that detainees assigned to administrative segregation for any reason must go before the Classification Committee on a weekly basis. However, the PSA Compliance Manager advised that victims of sexual abuse are housed in the intake area no longer than five days. Based on the information provided, the Auditor was unable to clarify whether detainee victims of sexual abuse were reassigned to administrative housing for a week or more or just sent to the intake unit for no longer than five days. The Auditor recommends the facility's policy and practice of placing sexual abuse detainee victims into administrative housing aligns with the requirements of subsections (a) which mandates the facility to "place detainee victims of sexual abuse into a supportive environment that represents the least restrictive housing option possible (e.g., protective custody), subject to the requirements of § 115.43" and subsection (b) that requires such placement to be no more than five days except in extenuating circumstances.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The Auditor determined compliance with the subpart of the standard based on review of SOP 1517 that states, "All allegations of sexual abuse will be investigated promptly, thoroughly, and objectively by specially trained investigators. If the allegation is against medical and mental health staff, investigators, or the facility administrator the highest-ranking staff member not involved shall investigate." The Auditor conducted two investigative file reviews and found that both sexual abuse allegations had undergone an administrative investigation. The two investigative file reviews reflected that the victim, the abuser, and witnesses were interviewed, a description of evidence was indicated, and a comprehensive report was completed.

Does Not Meet (a): The Auditor was unable to determine compliance with this subpart of the standard**.** The current policy reflects that anyone, specially trained or not, can conduct an investigation into sexual abuse involving the aforementioned staff. In addition, a review of the curriculum confirms the investigator has not received training on cross agency coordination. To confirm compliance, the Auditor recommends the facility update the policy to reflect if the allegation is against medical or mental health staff, an investigator, or the facility administrator, the highest ranking specially trained investigator will conduct the interview. In addition, similar to 115.34, the facility must update their lesson plan to reflect cross agency coordination as required by the standard and provide the Auditor with updated lesson plan. The facility must provide the Auditor with documentation that the assigned facility investigator received training on the updated lesson plan.

(b)(c)(e)(f): The Auditor reviewed SOP 1517 that states, "Administrative investigations will include an effort whether staff actions or failures to act contributed to the abuse. PCCF's investigators are responsible for investigating all allegations of sexual abuse and sexual harassment. All allegations will be investigated promptly, thoroughly, and objectively by facility investigators who received special training in sexual abuse investigations in confinement settings. The facility investigators will gather and preserve direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data. They will interview the alleged victims, suspected perpetrators and witnesses and review prior complaints and reports of sexual abuse involving the suspected perpetrator. If criminal activity is determined by the facility investigator, the PSP will be contacted. All information will be forwarded to the PSP for possible criminal charges." Should it be determined such allegation is of a criminal nature, the allegation will be referred to PSP. PCCF's investigators shall preserve 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; and 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." Also, SOP 1517 states, "The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation**.**" In an interview with the PSA Compliance Manager, it was indicated that the facility would remain informed about the progress of the outside agency's investigation progress; however, the PSA Compliance Manager could not outline a facility practice that would be followed to confirm that the facility was informed of the outside agency's investigation progress. The PSA Compliance Manager further stated that the investigation of sexual abuse would continue even if a detainee victim or abuser is no longer housed at PCCF. The Warden and PSA Compliance Manager verified that an administrative investigation is conducted on all allegations of sexual abuse in addition to any criminal investigations. The Warden indicated that a review of the incident is conducted during incident reviews. The two investigative file reviews reflected that the victim, the abuser, and witnesses were interviewed, a description of evidence was indicated, and a comprehensive report was completed. As both investigations deemed to not be criminal in nature the cases were not referred to the PSP.

Does Not Meet (f): The facility is not in compliance with subsection (f) of the standard. In an interview, the PSA Compliance Manager could not articulate a facility practice that would confirm that the facility would be informed of the outside agency's progress in an investigation of sexual abuse. To become compliant, the facility must develop a practice to include specifics as to what the Investigator's responsibility is in determining the progress of an outside agency sexual abuse investigation. In addition, the facility must document that all applicable staff have been trained in the new practice. The facility must, if available, provide the Auditor with any investigation files that were referred to the PSP to confirm that the facility was kept informed of the progress of the ongoing investigation.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with the standard based on review of SOP 1517 that states, "PCCF will impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated." The Auditor conducted two investigative file reviews of allegations of sexual abuse and documentation reflected the facility investigators used the standard of preponderance of evidence to determine the outcome of the case findings.

§115.73 - Reporting to detainees.

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

The Auditor determined compliance with the standard based on review of SOP 1517 that states, "Upon completion of an investigation of sexual abuse, and if the detainee is still in the facility, the detainee will be notified of the following: 1) when staff member is no longer posted within the detainee's assigned housing unit; the staff member is no longer employed with PCCF; the staff member or detainee has been indicted or convicted on a charge related to sexual abuse within PCCF." The facility's policy also states, "that the facility will notify the detainee of the outcome of the investigation in writing." The SOP also states that "PCCF is not obligated to report this information if the detainee is released from PCCF's custody." The Auditor reviewed a memorandum (dated 6/10/21) from the PSA Compliance Manager to the detainee informing the detainee that his case of sexual harassment had been investigated and closed with an unfounded finding. The Warden verified that detainees are informed of their case status in writing. The Auditor conducted two investigative file reviews of sexual abuse allegations reported at PCCF and both investigative files included a copy of a memorandum from the PSA Compliance Manager addressed to the detainees informing the detainees of their case findings. Both allegations were determined to be unfounded.

§115.76 - Disciplinary sanctions for staff.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c)(d): The Auditor reviewed SOP 2401 and SOP 1517 which state, "Termination is the presumed sanction for staff when their investigation of sexual abuse has been substantiated." The policies also state, "PCCF will report all employee terminations and resignations as a result of violating PCCF's sexual abuse policy to any relevant licensing bodies, to the extent known, and PSP if of a criminal nature." A review of both policies indicate that neither were reviewed and approved by the Agency, nor do they contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards." In addition, neither policy indicates that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse or a detainee by a staff member, contractor, or volunteer." The Auditor reviewed a memorandum (dated 11/18/21) from the PSA Compliance Manager stating there were no staff resignation, termination, or discipline for violating the facility's policy on sexual abuse within the past 12 months. In addition, the Warden stated staff would be removed, placed on administrative leave, and even terminated depending on the outcome of investigation. The Auditor conducted two investigative file reviews of sexual abuse allegations against staff and found that both investigations concluded with an unfounded finding.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of both policies indicate that neither were reviewed and approved by the Agency, nor do they contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards." In addition, neither policy indicates that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." To become compliant with subsections (a) and (b), the facility must update SOP 2401 and SOP 1517 to include the required verbiage of the standard. In addition, if applicable, provide investigation files that confirm a staff member was disciplined in accordance the standard 115.76 after an incident of substantiated sexual abuse.

§115.77 - Corrective action for contractors and volunteers.

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

(a)(b)(c): The Auditor reviewed SOP 1517 and all other policies provided. The policy addressed staff but did not address corrective action for contractors and volunteers who violate the facility's zero-tolerance policy. The Auditor reviewed a memorandum from the PSA Compliance Manager (dated 11/17/21) that stated that there was no need to contact a licensing entity as there were no contractors or volunteers who have violated the facility's sexual abuse policy. The Auditor conducted two investigative file reviews of sexual abuse allegations reported at PCCF within the past 12 months. The auditor found that both investigations involved a staff perpetrator, not contractors or volunteers. The Warden's interview confirmed that contractors and volunteers would be prohibited from having contact with detainee victims, removed, or even terminated depending on the outcome of the investigation.

Recommendation: The Auditor recommends the facility's policy be updated to address how a detainee victim would be protected from a contractor or volunteer perpetrator of sexual abuse.

§115.78 - Disciplinary sanctions for detainees.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on review of SOP 1020.1 that states, "Sexual abuse is an extreme rule violation that may result in a disciplinary hearing, 60 days restrictive housing and/or loss of privileges and/or monetary restitution, as determined by the Disciplinary Board. Criminal activity will be reported to the PSP for investigation." SOP 1020 states "detainees will be required to conform to the standards of conduct reflected in PCCF's rules and regulations. A detainee violating any facility rule may be subject to disciplinary action. Disciplinary actions will not be capricious or retaliatory, nor based on race, religion, national origin, sex, sexual orientation, disability, or political beliefs. This policy states that sanctions shall be

commensurate with the severity of the committed prohibited act." A properly managed detainee disciplinary program will serve to maintain security, control, and safety. This ensures due process rights and ensures fair and consistent disciplinary practices. Discipline will not be imposed unless the detainee has been informed of the offense charged in writing, has had an opportunity to present a defense and has been found guilty of the charge by an impartial disciplinary board designed by the Warden. A detainee shall not be held accountable for his or her conduct if a medical authority finds him or her mentally incompetent." The Auditor conducted two investigative file reviews of sexual abuse and found that neither involved a detainee perpetrator. The Auditor reviewed a memorandum (dated 11/17/21) from the PSA Compliance Manager stating there were no detainees disciplined for engaging in sexual abuse within the past 12 months.

(e)(f) The Auditor reviewed SOP 1517 that states, "A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The Auditor confirmed through investigative file reviews that there was no detainee disciplined for making a sexual abuse report within the past 12 months. However, SOP 1517 did not include verbiage supporting a detainee would not be disciplined for sexual contact with staff unless there is a finding that the staff member did not consent to such contact, nor did interviews support this practice would be adhered to.

Does Not Meet (e): The Auditor was unable to determine compliance with this subpart of the standard. The facility was unable to provide documentation indicating the facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. To confirm compliance, the Auditor recommends the facility to update policy reflecting this requirement.

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

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

Notes:

(a)(b)(c) The Auditor reviewed Policy 1517 stating if a detainee reports a history of sexual abuse during intake, the detainee is referred to a mental health practitioner within 14 days. PCCF PrimeCare Policy C, J-F-06 (Response to Sexual Abuse) states that "if a detainee reports sexual abuse victimization occurred within 96 hours of entering the facility, the detainee should be sent to the Emergency Room for forensic medical examination. A referral will be made to have the detainee seen by a psychologist." The Auditor reviewed a memorandum (dated 11/19/21) from the PSA Compliance Manager stating there were no mental health follow-ups conducted as a result of a detainee's prior sexual abuse victimization within the past 12 months. When interviewed, the Behavioral Health Director reported that if a detainee has experienced prior sexual abuse victimization or perpetrated sexual abuse, an immediate referral is made to medical and her department for follow-up. The Behavioral Health Director reported that detainees must be seen by mental health staff within 24 hours. She also reported that all detainees are placed on a 90-day mental health follow-up upon entering the facility. The Vice President of PrimeCare reported that medical staff must follow-up with a detainee within four hours of receiving information on their sexual abuse history. The Classification Coordinator stated that an immediate referral is sent to medical for follow-up.

Recommendation: Although the standard does not require a policy and the above interviews demonstrate the facility's compliance with this standard, SOP 1517 states that detainees who have reported a history of sexual abuse during intake will be referred to a mental health practitioner within 14 days. However, the Auditor strongly recommends the facility's policy be updated to reflect the specific requirements of: (1) subsection (b), which requires that when the referral is to medical, the detainee shall receive a medical evaluation no later than two working days from the date of the assessment, and (2) subsection (c), which requires that when a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of SOP 1517 and PCCF PrimeCare Policy C, J-F-06 stating "detainee victims of sexual abuse have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and that emergency medical treatment services provided to the victim shall be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." In interviews with the Vice President of PrimeCare, the Regional Medical Director, and the Behavioral Health Director, all indicated that detainee victims of sexual abuse while detained are offered tests for sexually transmitted infections and that treatment services are provided to detainee victims at no cost regardless of whether the victim names the abuser or cooperates with the investigation. The Auditor reviewed a memorandum (dated 11/19/21) from the PSA Compliance Manager stating there was no emergency medical treatment provided to a detainee as a result of sexual abuse within the past 12 months. The Auditor reviewed two investigative files and determined the detainees were not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. Following the incidents, one detainee stated he did not need medical services; and therefore, was not taken to medical for assessment. The review of the second investigative file indicates that the detainee was not taken to medical for treatment after the incident. In an interview with the second detainee, he indicated that he was seen by Mental Health but did not report that he was seen by medical.

Does Not Meet (a): The facility is not compliant with section (a) of the standard. The Auditor reviewed two investigative files and determined that neither detainee was provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. In one incident, the detainee refused medical treatment, and in the second incident there is no indication that the detainee was offered medical treatment, and therefore the Auditor could not confirm either detainee was taken to medical for assessment. However, the standard requires timely, unimpeded access to medical, where the refusal of services can be made directly to medical staff who would be the appropriate individuals to assess needs for medical services, and that assessment or declination of assessment documented in the detainee's medical file. To become compliant, the facility must develop a protocol that ensures detainee victims are afforded timely, unimpeded access to medical and mental health services after every reported incident of sexual abuse. In addition, the staff must be trained on the new protocol and the training must be documented.

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

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

Notes:

(a)(b)(c)(d)(e)(f)(g) The Auditor determined compliance with these subparts of the standard based on SOP 1517 stating that "PCCF offers medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention." SOP 1517 and PCCF PrimeCare Policy C, J-F-06 further stated "detainee victims of sexual abuse have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and that emergency medical treatment services provided to the victim shall be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." SOP 1517 and PCCF PrimeCare Policy C, J-F-06 state "detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests and all lawful pregnancy related medical services, if applicable." SOP 1517, the PCCF PrimeCare Policy C, J-F-06, the Vice President of PrimeCare, the Regional Medical Director, and the Behavioral Health Director indicated that detainee victims of sexual abuse while detained are offered tests for sexually transmitted infections and that treatment services are provided to detainee victims at no cost regardless of whether the victim names the abuser or cooperates with the investigation. PCCF PrimeCare Policy C, J-F-06 indicates that the facility "shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." The Auditor reviewed a memorandum (dated 11/19/21) from the PSA Compliance Manager stating there were no instances of detainee-on-detainee sexual abuse within the past 12 months. The Vice President of PrimeCare, the Regional Medical Director, and the Behavioral Health Director indicated that the evaluation and treatment of sexual abuse victims include follow-up services, treatment plans, and needed referrals for continued care consistent with the community level of care. In addition, the Vice President of PrimeCare and the Regional Medical Director reported that referrals for continued medical care are included in the Electronic Medical Record (EMR) to accompany the detainee victim upon discharge or transfer. Both policies and medical staff indicated detainee victims of sexual abuse while detained are "offered tests for sexually transmitted infections and that treatment services are provided to detainee victims at no cost regardless of whether the victim names the abuser or cooperates with the investigation." There was no indication of a female detainee victim of sexual abuse through detainee file reviews and other documentation provided by the facility. The PSA Compliance Manager and other staff confirmed there were no female detainees housed at PCCF during the onsite audit. There was no indication of a detainee victim receiving outside medical treatment that would require follow-up treatment according to the investigative and detainee file reviews.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on review of SOP 1517 which states, "PCCF shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the agency PSA Coordinator. PCCF's review team consists of the Warden, Assistant Wardens, PSA Compliance Manager, facility investigators, and medical staff. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility." The Auditor reviewed memorandum (dated 11/19/21) from the PSA Compliance Manager stating there were no cases of sexual abuse to recommend or implement changes within the past 12 months. The PSA Compliance Manager reported that an incident review is immediately conducted after each sexual abuse investigation has been completed. The Auditor conducted two investigative file reviews of sexual abuse allegations reported at PCCF and found that an incident review was conducted within 30 days after the conclusion of the investigation. Also, the Auditor reviewed a memorandum (12/15/21) from the PSA Compliance Manager stating an Annual Review of two PREA related complaints was conducted by the Warden, SDDO, and the PREA Coordinator. According to the memorandum, the necessity for surveillance cameras, facility modifications, and staffing levels were discussed, and they determined there were no changes or modifications needed at the time. The PSA Compliance Manager further confirmed during interview that PCCF conducts an annual review of the facility's sexual abuse investigations and incident reviews; however, the facility was unable to provide documentation supporting the review was sent to the FOD and Agency PSA Coordinator.

Does Not Meet (c): The facility is not compliant with subsection (c) of the standard. A review of the annual review, in conjunction with the Warden and PSA Compliance Manager interviews, could not confirm that the facility sent the review to the FOD and the

Agency PSA Coordinator. To become compliant, the facility must send the annual review to the FOD and Agency PSA Coordinator and provide documentation that it was sent.

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

(a): The Auditor determined compliance on this subpart of the standard after review of SOP 1517 that states, "Sexual abuse documentation is retained for at least 10 years after the date of initial collection." The PSA Compliance Manager reported that all records pertaining to sexual abuse are kept in a locked file cabinet in his office. The Auditor verified the sexual abuse files were locked in the PSA Compliance Manager's office which is also kept locked.

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

(d) The Auditor was allowed access to the entire facility and able to interview staff and detainees about sexual safety during the audit visit.
(e) The Auditor was able to revisit areas of the facility and to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j) Audit notices were posted and observed throughout the facility in English and Spanish. The Auditor received no staff or detainee correspondence.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	15
Number of standards not met:	24
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Cicily Harrington 3/12/2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) 3/13/2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 3/15/2022
Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Cicily Harrington	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-285-[redacted]
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-579-[redacted]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Philadelphia Field Office		
Field Office Director:	Brian McShane		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	114 North 8th Street, Philadelphia, PA 1907		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Pike County Correctional Facility		
Physical address:	175 Pike County Boulevard, Lords Valley, PA 18428		
Mailing address: *(if different from above)*			
Telephone number:	215-656-7164		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	Craig Lowe	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	570-775-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Lieutenant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	570-775-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of Pike County Correctional Facility (PCCF) was conducted on January 11–13, 2022, by U. S. Department of Justice (DOJ) and DHS, certified PREA auditor Cicily Harrington employed by Creative Corrections, LLC. The Auditor was provided guidance during the report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM), [redacted] and Assistant Program Manager (APM), [redacted] both are DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The facility processes detainees who are pending immigration review or deportation. The PREA Incorporation date was December 12, 2019. This was the first DHS PREA audit for PCCF and included a review of the 12-month audit period from January 12, 2021, through January 13, 2022. PCCF is in Lords Valley, Pennsylvania.

Upon completion of the audit, PCCF was found to be non-compliant with 25 standards:

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.61 Staff reporting duties
§115.64 Responder duties
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.71 Criminal and Administrative Investigations
§115.76 Disciplinary sanctions for staff
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.86 Sexual abuse incident reviews

The facility's Corrective Action Period (CAP) began March 15, 2022, and ended September 11, 2022. The facility submitted documentation, through the Agency, for the CAP on April 4, 2022, through September 9, 2022. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on September 9, 2022. In a review of the submitted documentation to demonstrate compliance with the deficient standards, the Auditor determined compliance with 21 of the standards and found that 4 standards: §115.41 Assessment for risk of victimization and abusiveness, §115.42 Use of assessment information, §115.67 Agency protection against retaliation, and §115.82 Access to emergency medical and mental health services, remained non-compliant based on submitted documentation or lack thereof.

PROVISIONS

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

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

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

(c): The Auditor reviewed Standard Operating Procedure (SOP) 1517 (Sexual Misconduct/Assault) which mandates zero-tolerance toward all forms of sexual abuse and outlines PCCF's approach to prevent, detect, and respond to sexual abuse. The approach to accomplish this goal is through hiring practices and ensuring employees, contractors, volunteers, and detainees are informed of the facility's zero-tolerance policy and procedures pursuant to sexual abuse and sexual misconduct. The random staff and detainees interviewed indicated they are aware of the facility's sexual abuse policy. However, the facility did not provide the Auditor with documentation confirming the Agency reviewed and approved PCCF's zero-tolerance policy.

Does Not Meet (c): The facility does not meet standard 115.11 (c). The subsection requires that the Agency reviews and approves the facility's zero-tolerance policy. To become compliant the facility must forward SOP 1517 to the Agency for review and approval.

Corrective Action Taken (c): The facility provided the Auditor with an email dated August 19, 2020, entitled "PREA Policy and Procedure" which confirmed that on that date, the AFOD reviewed and approved SOP 1517. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsection (c) of the standard.

§115. 13 - Detainee supervision and monitoring

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

(a)(b)(c): The auditor reviewed PCCF's SOP 313 (Review of Staffing Requirements) that states, "The Assistant Warden shall prepare an annual comprehensive staffing analysis to determine staffing requirements. This analysis and any recommendations will be reviewed by the PSA Compliance Manager and submitted to the Warden. Staffing levels are based on generally accepted detention and correctional practices, findings from inspections, all components of the physical plant, composition of the detainee population, number and placement of supervisory staff, programs, applicable laws, regulations, standards, prevalence of substantiated and unsubstantiated incidents of sexual abuse and any other relevant factors." The Auditor reviewed the facility's Staff Coverage Plan Worksheet, which demonstrated adequate supervision of detainees on all three shifts. The Auditor reviewed the facility's staffing analysis which consisted of line staff, mid-level staff, upper-level staff, medical contractors, and maintenance staff on all three shifts demonstrating adequate levels of detainee supervision. The Auditor reviewed a checklist, confirming that the Annual Review and facility Post Orders for 2021 had been completed and updated. The PSA Compliance Manager verified the comprehensive guidelines are developed by the Warden and Assistant Warden and the Commissioner by considering "the physical layout, composition of staff to detainee, and determination of extra staff and mirrors." The Auditor toured the facility and found several blind spots in the following areas where there is at least a ratio of one detainee to one staff or two detainees to one staff: 1) laundry room, 2) barbershop, and 3) dry storage area in the kitchen. (b) (7)(E) [redacted] The Warden reported that PCCF has two camera systems: 1) Central Control which is in charge of monitoring all common areas, verifying individuals upon entering and exiting locations throughout the facility and door control; 2) Warden's Video Feed is a camera system that was installed in 2005; (b) (7)(E) [redacted] After the facility audit, the Auditor was provided a quote, a purchase order, and email correspondence between the Warden and the Sr. Account Manager (dated 1/19/22), demonstrating the initiation of implementing video surveillance in identified blind spots.

Does Not Meet (a): The Auditor identified several blind spots in areas where detainees and staff are consistently unsupervised; therefore, the Auditor could not confirm compliance with the standard that requires the facility to ensure that

it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. To confirm compliance, the facility must change its policy and practice to ensure detainees and staff are not left unattended in those identified areas and install the video surveillance cameras that were requested by the Warden on January 19, 2022, as noted above.

Corrective Action Taken (a): (b) (7)(E) [redacted] Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsection (a) of the standard.

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

(g): The Auditor reviewed SOP 1002 (Housing Unit Operations) that mandates, "Staff of the opposite gender to announce their presence when entering a housing unit." Five Correctional Officers were interviewed and all five stated prior to them entering a housing unit that houses detainees of the opposite gender, they announce their presence. All five Correctional Officers verified they have never seen detainees of the opposite gender shower, use the bathroom, and change clothing. The Auditor (female) was accompanied by the Audit Team Lead (female), the PSA Compliance Manager and the Audit Team Lead's partner, and upon entering the male detainee housing unit, there was no announcement of the opposite gender entering the unit; and therefore, the auditor announced, "female presence." After entering another male housing unit during the audit tour, the officer announced, "females on." (b) (7)(E) [redacted] When asked, the medical intake staff and the Warden informed that when a detainee is being examined by medical staff, the portable (three-faced) medical privacy screen is set up around the examination table to ensure privacy. The Auditor observed the medical privacy screen in the medical area during the audit tour. (b) (7)(E) [redacted] The Auditor entered the restrictive housing unit, although there were no detainees currently housed, the auditor observed an exposed gated shower door with no curtain or covering. The auditor was advised that a curtain would be placed in the shower area to prohibit cross-gender viewing if the unit was occupied. The auditor recommended they keep the shower curtain in place in case they must immediately place a detainee into restrictive housing.

Does Not Meet (g): The facility was unable to demonstrate how it ensures the privacy of detainees to shower, use the bathroom, and change clothing without staff of the opposite gender viewing. To confirm compliance, the auditor recommends the facility re-train staff on announcing their presence or the presence of anyone who is of the opposite gender prior to entering a housing unit. In addition, to prohibit staff of the opposite gender from viewing detainees while using the bathroom in the intake observational cells, the facility must incorporate a blocking or shading mechanism into their camera system to shade the toilet area thus allowing the detainee privacy when using the bathroom. The facility must provide documentation through pictures that the addition of the blocking or shading mechanism has been added.

Corrective Action Taken (g): The facility provided electronic training records confirming applicable staff were trained on policy 1002 and the requirement to announce their presence or the presence of anyone who is of the opposite gender prior to entering a housing unit. In addition, the facility submitted a memo from a security supervisor confirming the use of the shower curtains installed in the restrictive housing unit shower. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsection (g) of the standard.

§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): The Auditor reviewed SOP 1105 (Special Needs Inmates/Detainees Identification). The policy states, "PCCF will ensure that inmates/detainees with special needs (deaf, hard of hearing, limited reading skills, blind or low vision) will be provided with a counselor to assist with reading and assistance with communication. An UltraTech Communications (TTY) system is available." In addition, SOP 1517 and the PCCF Detainee Handbook, state "A detainee with disabilities is provided with a counselor to assist with communications and that text telephone (TTY) is available for detainees who are deaf or hard of hearing; detainees with the above disabilities or challenges must submit a request for assistance to their housing unit counselor." The Classification Coordinator, the Behavioral Health Director and the Regional Medical Director were interviewed and indicated that sexual abuse information videos, PCCF Detainee Handbooks (English and Spanish), ICE National Detainee Handbooks, interpreter services, translation services, and staff interpreters are used to assist detainees who are deaf or hard of hearing, LEP, blind or low vision, have intellectual, psychiatric, or speech disabilities, and limited

reading skills. The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The Auditor observed ICE zero-tolerance posters written in English and Spanish indicating the PSA Compliance Manager's name on housing unit bulletin boards and ERO Language Services posted for detainees to request translation or transcription services. The DHS-prescribed ICE Sexual Abuse Awareness Information postage is available in English and Spanish and Sexual Abuse Assault and Prevention Program (SAAPI) pamphlets were provided to the detainees upon intake. The intake staff could not explain how the detainees would receive the pamphlet in the other seven languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, which are also available by the agency. Also, the Classification Coordinator informed the auditor that if the detainee's language was not available in written materials, she and intake staff would utilize interpreter services to provide sexual abuse prevention information to the detainee during intake. Detainees who are blind or who have low vision are provided individualized services by medical staff or the Classification Coordinator to include reading information to the detainee if needed. The Warden advised that PCCF's detainees are provided several accommodations to assist with disabilities such as: TTY machine, extended visitation time and video conferencing, medical staff in-person assistance, and interpreter services. Of the 12 detainee files reviewed by the Auditor, 8 of the files indicated that the detainee was English speaking; however, interviews with the corresponding 8 detainees, indicated that 5 the detainees interviewed preferred language was other than English. This was confirmed by the Auditor having to use interpretative services to effectively conduct interviews with all eight detainees.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. Intake staff, during their interviews, did not know how to access the DHS-prescribed Sexual Assault Awareness Information pamphlet in languages other than English and Spanish. In addition, although policy and staff interviews reflect that LEP detainees are provided zero-tolerance information, the Auditor was unable to confirm compliance. The Auditor interviewed and conducted file reviews of 12 detainees. Although, eight of the files indicated that the detainee was English speaking, interviews with the corresponding eight detainees, during which the Auditor had to use interpretative services to effectively communicate with them, indicated that five of the detainees interviewed preferred language was other than English. As five detainee files did not accurately reflect their preferred language, the Auditor could not determine that the detainees were provided meaningful access to the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse in a manner that they could understand. To confirm compliance, the facility must develop a practice that includes providing the detainee with all aspects of the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse, including, but not limited to, providing the detainee with a copy of the DHS-prescribed ICE Sexual Awareness Information pamphlet, in their preferred language. In addition, the Auditor requires the facility to train all applicable staff on the new procedure and to provide documentation of such training. The facility must also provide the Auditor with 10 detainee files of detainees who arrived on different days, and are not proficient in English or Spanish, confirming that the detainees have received all the aspects of the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse, including, but not limited to, providing the detainee with a copy of the DHS-prescribed ICE Sexual Assault Awareness Information pamphlet.

Corrective Action Taken (b): The facility submitted a copy of updated SOP 1904 which states that ICE detainees will be provided with the DHS-prescribed Sexual Assault Awareness Information pamphlet in their preferred language, copies of the facility's detainee handbook in the following languages: English, Spanish, French, German, Haitian Creole, Maltese, Polish, Portuguese, Chinese, Russian, and Vietnamese, and copies of the DHS-prescribed Sexual Assault Awareness Information pamphlets in Portuguese, Punjabi, Arabic, Haitian Creole, Hindi, and Chinese. In addition, the facility provided the Auditor a memo dated 9/2/2022 that states, "Please be advised that no additional detainees have been committed to the PCCF during the CAP period whose preference language is other than English or Spanish." A review of the submitted documentation confirms that the facility did not upload the DHS-prescribed Sexual Assault Information pamphlet in the French; however, upon review of the submitted documentation, the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

§115.21 - Evidence protocols and forensic medical examinations
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a): The Auditor determined compliance with this subpart of the standard based on review of SOP 1517 that states, "The facility is responsible for investigating allegations of sexual abuse and sexual harassment. All allegations will be investigated promptly, thoroughly, and objectively by facility investigators who received special training in sexual abuse investigations in confinement settings." The policy includes a uniform evidence protocol that requires "The facility investigators will gather and preserve direct and circumstantial evidence, including any physical DNA evidence and any available electronic monitoring data" and "If criminal activity is determined by the facility investigator, the Pennsylvania State Police (PSP) will be contacted." The PSA Compliance Manager confirmed PCCF's uniform evidence collection protocol and advised there are no juveniles housed at PCCF. The Auditor reviewed two sexual abuse investigations conducted at PCCF within the past 12 months and determined that a uniform evidence protocol ensures preservation of evidence. A review of the protocol, in

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

Does Not Meet (a): The facility does not meet standard 115.21 (a). The subsection requires that the protocol be developed in coordination with DHS. To become compliant the facility must forward their investigative protocol to DHS for review and approval.

Corrective Action Taken (a): The facility provided the Auditor with an email dated August 19, 2020, entitled "PREA Policy and Procedure," which confirmed that the AFOD reviewed and approved SOP 1517 which includes the investigative protocol. Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsection (a) of the standard.

(e): The Auditor reviewed SOP 1517 and found no indication of PCCF requesting, or attempting to request PSP, to follow the requirements of paragraphs (a) through (d) of this section. The PSA Compliance Manager confirmed during the interview that PSP investigates all PCCF's criminal investigations of sexual abuse. The auditor was provided with and reviewed a memorandum (dated 12/17/21) written by the PSA Compliance Manager confirming that PSP conducts all PCCF criminal investigations into sexual abuse. This memorandum was signed by a PSP lieutenant.

Does Not Meet (e): The Auditor was unable to confirm compliance with this subpart of the standard. The facility did not provide the Auditor with documentation confirming that the facility requested or attempted to request PSP to follow the requirements of paragraphs (a) through (d) as required by subsection (e) of the standard. To confirm compliance, the auditor recommends the facility request a detailed memorandum of understanding between PCCF and PSP addressing the requirements of subparts (a) through (e).

Corrective Action Taken (e): The facility submitted a copy of a proposed MOU sent to the PSP requesting they follow the requirements of subsections (a) through (d) as required by the standard. In addition, the facility submitted a reply dated July 28, 2022, from a PSP Lieutenant indicating that PSP was unable to sign the MOU. Based on the facilities attempt to have the PSP follow the requirements of subsections (a) through (d), the Auditor now finds the facility in substantial compliance with subsection (e) of the standard.

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

(a)(b)(c): The Auditor determined compliance with the subparts of the standard based on review of Agency policy 11062.2 Sexual Abuse and Assault Prevention and Intervention, section 5.7, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (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. The JIC shall notify the DHS Office of Inspector General (OIG)." In addition, SOP 1517 that states, "The Warden, PSA Compliance Manager, or designee will contact PSP to conduct an official investigation into sexual abuse, notify the Field Office Director, notify ICE Supervisory Detention and Deportation Officer (SDDO) and the SDDO will notify the OPR. All written documentation pertaining to sexual abuse and sexual harassment investigations are retained for at least five years as long as the alleged abuser is incarcerated or employed by the agency plus an additional five years." A memorandum (dated 12/17/21) from the PSA Compliance Manager indicated that the PSP conducts PCCF's criminal investigations into sexual abuse. The PCCF Detainee Handbook indicated the facility's investigative protocol. The PSA Compliance Manager confirmed that PCCF would provide the agency with all collected information pertaining to the sexual abuse allegation to assist with the agency's investigation. The Warden verified that the facility provides the ICE Field Office with collected information pertaining to the sexual abuse

allegation received. The Warden stated the PSA Compliance Manager and Assistant Warden sends an email to the assigned ICE Field Office. The Auditor reviewed the mass email generated notifying the ICE Field Office on a sexual abuse allegation received by the facility and confirmed compliance. The PSA Compliance Manager reported that all allegations into sexual abuse begin administratively and are referred to the PSP if there is a criminal component and indicated that PCCF posts its protocols on the facility's website at www.pikepa.org. The Auditor reviewed PCCF's website which included the facility's zero-tolerance policy and reporting procedures; however, the website did not indicate the facility's protocol to ensure that each allegation of sexual abuse is investigated by the agency or facility or referred to an appropriate investigative authority. The Auditor reviewed the ICE website, (https://www.ice.gov/prea), which provided the required Agency protocol.

Does Not Meet (c): The Auditor was unable to confirm compliance with this subpart of the standard as the facility's website does not include PCCF's investigation protocol. To confirm compliance, the facility must indicate PCCF's protocol on its website, or otherwise make the protocol available to the public, ensure that each allegation of sexual abuse is investigated by the agency or facility and/or referred to an appropriate investigative authority.

Corrective Action Taken (c): The Auditor reviewed the facility website and confirmed that it now includes the PCCF protocol. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsection (c) of the standard.

§115.31 - Staff training
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): SOP 1517 states, "PREA, sexual abuse and harassment are covered at least twice a year during shift briefings." The Auditor was provided with the Correctional Officers' Basic Training Lesson Plan on Inmate Sexual Assaults, Sexual Assaults Prevention/Intervention, and during the Auditor's review, it was found that the Lesson Plan belongs to Kansas Department of Corrections. The Training Supervisor reported that all facility staff who have contact with detainees receive training on PCCF's zero-tolerance policy, definitions pertaining to sexual abuse, recognition of situations where sexual abuse may occur, how to avoid inappropriate relationships with detainees, and effective communication with lesbian, gay, bisexual, transgender, and intersex (LGBTI) detainees; however, upon review by the Auditor, it was determined the lesson plan on Inmate Sexual Assaults, Sexual Assault Prevention/Intervention did not reflect effective communications with LGBTI detainees. The Auditor also observed that the lesson plan's objectives did not include PCCF's zero-tolerance policy, sexual assault, and prevention to reflect the actual dynamics of sexual abuse at PCCF, a detainee's right to be free from sexual abuse, and a detainee and staff's right to be free from retaliation for reporting sexual abuse. The Training Supervisor advised that he would conduct research to obtain a Lesson Plan that would address effective communication with LGBTI detainees. Five Correctional Officers were interviewed and confirmed they had received training on PCCF's zero-tolerance policy, sexual abuse prevention, reporting mechanisms, and response. The officers indicated their training did not include effective communication techniques with LGBTI detainees. Prior to the audit closeout, the Training Supervisor presented the Auditor with a Lesson Plan addressing effective communication with LGBTI detainees in confinement settings. The Auditor reviewed and confirmed that the Lesson Plan would provide PCCF's staff with the training needed. The Training Supervisor advised that the Lesson Plan would be included in the staff's training curriculum. The Auditor reviewed training reports/rosters confirming 225 employees had received PREA and Sexual Misconduct Training within the past 12 months including, but not limited to, "Lock Up USA Complying with PREA for the C.O," which included the facility's zero-tolerance policy, definition and examples of prohibited and illegal sexual behavior, recognition of situations where sexual abuse may occur, recognition of physical, behavioral, avoiding inappropriate behavior, and emotional signs of sexual abuse, reporting procedures, and preventing and response mechanisms" received during roll call on all three shifts. A review of additional training records of 11 employees acknowledged receipt of PREA and Sexual Awareness training within the past 12 months. However, the training does not address a detainee's right to be free from sexual abuse, or a detainee and staff's right to be free from retaliation for reporting sexual abuse. The Training Supervisor, along with the Auditor's review of 11 employee training records, confirmed that all facility staff who have contact with detainees receive refresher training on sexual abuse prevention and response twice a year. Five Correctional Officers were interviewed, and when asked, four of them stated that they received refresher training throughout the year. The other Correctional Officer reported he was a new employee.

Does Not Meet (a): Although the facility ensures staff are trained on PCCF's zero-tolerance policy, sexual abuse prevention, reporting mechanisms, and response, the facility was unable to provide the Auditor with sufficient documentation to determine compliance with all training requirements for this subpart. To confirm compliance, the Auditor recommends the Training Supervisor develop PCCF's own Lesson Plan addressing detainee sexual assault and prevention to reflect the actual dynamics of sexual abuse at PCCF, a detainee's right to be free from sexual abuse, and a detainee and staff's right to be free from retaliation for reporting sexual abuse. The Auditor also recommends the Training Supervisor include information regarding how to effectively communicate with LGBTI detainees. In addition, the facility must document that staff have received the added training as required by the standard.

Corrective Action Taken (a): The facility provided a training curriculum that includes a detainee's and staff's right to be free from retaliation and from retaliation for reporting sexual abuse, how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, and gender non-confirming, and the prevention of sexual assault in regard to the actual dynamics of sexual abuse at PCCF. In addition, the facility provided copies of training logs confirming that staff received the required training. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsection (a) of the standard.

§115.32 - Other training
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): SOP 2401 (Citizen Involvement/Volunteers) states, "Volunteers must complete orientation and training program prior to their assignment." In addition, SOP 1517 states, "Prime Care medical staff are trained on the agency's zero tolerance policy, their responsibilities on prevention, detection, intervention, response, and reporting." Currently, PrimeCare staff are the only contractors who have recurring contact with detainees. However, should there be additional contractors assigned to work at PCCF, the above policy would not address those contractors. PCCF Volunteer Orientation Receipt forms were provided to reflect approximately 45 volunteers had received sexual abuse prevention, detection, and response training. The Auditor interviewed three medical contractors (the Vice President of PrimeCare, the Regional Medical Director and the Behavioral Health Director) and confirmed themselves, and their staff, had received annual PREA training on the facility's zero-tolerance policy. The Auditor confirmed contractor training through training reports/rosters that were reviewed.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. The facility's practice does not include providing training to other contractors who have contact with detainees on their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures based on the services they provide. In addition, the facility's practice does not require that the facility document that the contractor received the training as required by the standard. In addition, during interviews, staff could not confirm compliance with training other contractors. To become compliant with subsections (a) and (b) of the standard, the facility must update their practice to include other contractors and provide the Auditor with confirmation of such change. In addition, if applicable, the facility must provide the Auditor with documentation that all other contractors have been trained on their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention, and response procedures, including the Agency's and facility's zero-tolerance policies regarding sexual abuse and information on how to report such incidents. The training must be documented as required by subsection (c) of the standard.

Corrective Action Taken (a)(b)(c): The facility submitted signed documented training for other contractors entitled Contractor Orientation that includes their responsibilities under the Agency's, and the facility's, sexual abuse prevention, detection, intervention, and response procedures, including the Agency's, and facility's, zero-tolerance policies regarding sexual abuse and information on how to report such incidents. Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

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

(a)(b)(c)(d)(e)(f): The Auditor reviewed SOP 1517, which states that "detainees are provided information on prevention, intervention, self-protection, reporting, treatment, access to outside victim advocate or rape crisis center, and counseling during the intake process." The ICE National Detainee Handbook, available in English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese; the PCCF Detainee Handbook available in English and Spanish; and the DHS-prescribed Sexual Abuse and Assault Prevention Intervention (SAAPI) pamphlet, all provide detainees with information pertaining to the facility's zero-tolerance policy, prevention and intervention strategies, definitions of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and reporting mechanisms to include reporting to staff and the OIG. In addition, the ICE National Detainee Handbook states, "No one can retaliate against you for reporting sexual abuse or assault, participating in an investigation about sexual abuse or assault, or participating in sexual activity as a result of force, coercion, threats, or fear of force." The SAAPI pamphlet informs detainees how to protect themselves from sexual abuse by not being afraid to say "NO," engaging in positive programs, expressing safety concerns or fears with a trusted staff member, trusting their instincts to remove themselves from an uncomfortable situation. According to the ICE Detainee Handbook, detainees are informed of the importance of receiving and participating in immediate medical treatment as well as their entitlement to ongoing medical care as needed. The Classification Coordinator stated that the orientation program on sexual abuse prevention and PCCF's zero-tolerance policy are provided through video and the PCCF Detainee Handbook. The Auditor observed that the video transcript was based on a PowerPoint presentation provided to detainees in English and Spanish which states that a

detainee may report sexual harassment or sexual abuse to a housing unit officer, Shift Commander, counselor, nurse, write a letter to the U.S. Marshal Service or OIG, or file an emergency grievance; the PowerPoint also states that victims of sexual abuse will be provided immediate and ongoing access to medical and mental health treatment and support services. According to the PowerPoint presentation, consensual and nonconsensual sexual activities are prohibited. The Classification Coordinator also stated that if the detainee's language was not available in written materials, she and her staff would utilize interpreter services to provide sexual abuse prevention information to detainees. Detainees who are blind or who have low vision are provided individualized services by medical staff or the Classification Coordinator to include reading information to the detainee if needed. The Warden advised that PCCF's detainees are provided several accommodations to assist with disabilities such as: Ultratech communications system (TTY), extended visitation time and video conferencing, medical staff in-person assistance, and interpreter services to ensure detainees receive information on the facility's prevention, detection, and response protocols pertaining to sexual abuse. The Auditor observed ICE Interpreter information flyers posted on the bulletin boards located on the housing units. In addition, The Auditor observed DHS-prescribed Sexual Assault Awareness notices (English and Spanish), Consulate notices, the PSA Compliance Manager's name posted on the ICE sexual abuse notices (English and Spanish), and VIP notices (English and Spanish) on the housing unit bulletin boards, detainee tablets, and throughout the facility. The Classification Coordinator advised that if the detainee's language is not available at the facility, she and her staff utilize a tablet to direct the detainee to select his language and read the ICE National Detainee Handbook which is provided in 14 languages: English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese. However, although the DHS-prescribed SAA pamphlet is distributed in either English or Spanish during intake, the Intake staff could not explain how the detainees would receive the DHS prescribed SAAPI pamphlet in the other 7 languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. The Auditor conducted 10 detainee file reviews and confirmed that all detainees were provided the ICE National Detainee Handbook and DHS prescribed SAA pamphlets. There was no indication of detainees signing their orientation packet to acknowledge receipt. The Classification Coordinator advised due to the spread of COVID 19, detainees have not been signing orientation documents but that she documents the detainees' receipt of orientation and places it in the detainee's file.

Does Not Meet (b): The Auditor was unable to determine compliance with this subpart of the standard. Although the facility provides the DHS-prescribed SAA pamphlet to the detainees upon intake, the facility was unable to provide the Auditor with how the facility would locate and provide the aforementioned pamphlet in languages other than English and Spanish during intake. To become compliant, the facility must adapt the practice of providing the DHS-prescribed Sexual Awareness pamphlet to LEP detainees in a language they understand. Once developed, all Intake staff must receive documented training on the new procedures. In addition, the facility must provide the Auditor with copies of 10 detainee files in languages other than English and Spanish that document the detainee received the DHS-prescribed ICE Sexual Abuse and Awareness pamphlet in their preferred language.

Corrective Action Taken (b): The facility submitted a copy of the updated SOP 1904, which states that ICE detainees will be provided with the DHS-prescribed SAA Information pamphlet in their preferred language, copies of the DHS-prescribed Sexual Assault Awareness Information pamphlets in Portuguese, Punjabi, Arabic, Haitian Creole, Hindi, and Chinese, and training logs confirming that staff were trained on the new procedure requiring detainees be provided with the DHS-prescribed SAA Information pamphlet in their preferred language. In addition, the facility provided a memo dated 9/2/2022 that states, "Please be advised that no additional detainees have been committed to the PCCF during the CAP period whose preference language is other than English or Spanish." A review of the submitted documentation confirms that the facility did not upload the DHS-prescribed Sexual Assault Information pamphlet in the French, however, upon review of the submitted documentation, the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

§115.34 - Specialized training: Investigations
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): The Auditor reviewed SOP 1517 that states, "All sexual abuse and sexual harassment allegations are to be conducted by PCCF staff assigned investigators who are specially trained on conducting investigations in confinement settings." The Auditor reviewed training certificates confirming the completion of specialized PREA investigative training for three facility investigators. The Training Supervisor verified that PCCF's assigned investigators have been specially trained to investigate sexual abuse in confinement settings, including him, although he doesn't conduct investigations. Also, during the Training Supervisor's interview, he provided the specialized training curriculum; the Auditor observed that the curriculum included techniques of investigating sexual abuse in confinement settings, Miranda and Garrity warnings, and evidence collection. The agency's Policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault training

curriculum, which covers in-depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. The Auditor did not observe any policy or lesson plan addressing effective cross-agency coordination for facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities.

Does Not Meet (a): The Auditor was unable to determine compliance with this subpart of the standard. The facility provided specialized training to assigned sexual abuse investigators; however, there was no documentation supporting facility investigators received training on cross-agency coordination. To become compliant, the facility must update their lesson plan to reflect cross agency coordination as required by the standard and provide the Auditor with updated lesson plan. In addition, the facility must provide the Auditor with documentation that the facility investigator received training on the updated lesson plan.

Corrective Action Taken (a): The facility provided the Auditor with their updated PREA Investigator lesson plan that confirms that the curriculum included a section on Cross - Agency Coordination. In addition, the facility submitted training documentation entitled, "PREA Cross Training for PREA Investigators," which confirmed all facility investigators received the required training. Upon review of all submitted documentation, the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.35 - Specialized training: Medical and mental health care
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(c): The Auditor reviewed SOP 1517 that states, "Prime Care medical staff are trained in the following: 1) how to detect and assess signs of sexual abuse, 2) how to respond effectively and professionally to victims of sexual abuse, 3) how and to whom to report allegations or suspicions of sexual abuse, how to preserve physical evidence of sexual abuse." The Auditor interviewed three medical contractors (the Vice President of PrimeCare, the Regional Medical Director, and the Behavioral Health Director); when asked, the Regional Medical Director and the Behavioral Health Director explained that they receive specialized medical training on an annual basis through Relias training system. The Training Supervisor verified that medical and mental health staff at PCCF receive specialized medical training through Relias and training on the facility's zero-tolerance policy as do all other staff at PCCF. The Regional Medical Director and the Behavioral Health Director reported that PCCF medical staff do not conduct forensic sexual abuse examinations.

Does Not Meet (c): The Auditor was unable to determine compliance. The facility was unable to provide the Auditor with documentation indicating that the facility forwarded SOP 1517 to the Agency for review and approval. In addition, the facility could not document that Prime Care medical staff and/or mental health staff were trained as required by SOP 1517. To become compliant, the facility must provide the Auditor with confirmation that the policy was submitted to the Agency for review and approval. In addition, the facility must provide the curriculum used to provide specialized training as required by SOP 1517 and documentation that all PrimeCare medical and mental health staff are trained as required by SOP 1517.

Corrective Action Taken (c): The facility provided the Auditor with training completion logs for medical indicating completion of a review of SOP 1517, which in conjunction with PREA training required in standard 115.31, covers all elements of the standard. Upon review of all submitted documentation, the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115.41 - Assessment or risk of victimization and abusiveness
Outcome: Does not Meet Standard
Notes:

(a)(b): The Auditor reviewed SOP 2002 (Classification/Orientation) which states, "The Classification Coordinator or designee will conduct an interview with all new intakes and complete the Classification Profile Worksheet in the Offender Management System." PCCF has a two-phase intake classification process. The first phase is conducted immediately upon intake and consists of a medical screening which is inclusive of the PREA initial assessment; this portion of the process is completed by medical staff. The second phase is conducted within three days of arrival and consists of the initial classification process, which is administered by the Classification Coordinator or designee. During interviews, the Classification Coordinator, the Regional Medical Director, and the Behavioral Health Director reported that PREA assessments are conducted by medical

staff during intake to determine detainees' risk for sexual victimization or sexual abusiveness and that detainees are kept separate from general population until classification is completed. The Classification Coordinator indicated that detainees who have not been classified are housed with detainees who have been classified but that they are kept separate. The PSA Compliance Manager reported that detainees are housed in the Classification Unit during the initial classification process on level one, level two, level three, or even restrictive housing. The Auditor verified the classification point system by review of 14 detainee's classification records; however only one file contained documentation that confirmed that a detainee had undergone an initial classification within 12 hours of admission. Seven detainees reported during their interviews that they had an initial PREA assessment with medical; however, there were some inconsistencies with the amount of time they were in the intake area. The classification records included the detainee's booking date but did not include the actual time of admission. Two of the detainees reported they were in intake for one to four days. The Classification Coordinator stated that detainees are given a three-day observational period prior to initial classification.

Does Not Meet (a)(b): Interviews with classification staff indicated that unclassified detainees are housed with detainees who are classified and that detainees are given a three-day observational period prior to initial classification and housing, which is inconsistent with subsection (a) of the standard that requires that the facility assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims, and, the requirement to keep separate all detainee new arrivals from the general population until he/she is classified and may be housed accordingly. In addition, the Auditor's review of 14 detainee records, with the exception of one file, could not confirm the initial classification and housing was completed within 12 hours as required by subsection (b) of the standard. To confirm compliance with subsections (a) and (b) of the standard, the facility needs to create, and implement, a practice which ensures the initial risk screening/classification process/housing assignment is completed within 12 hours and that arrivals are separated from general population until classified accordingly. In addition, the facility must provide 10 detainee files that clearly indicate that PCCF completed the initial risk screening on intake, the classification and housing assignment process within 12 hours, and detainees were kept separated from the general population.

Corrective Action Taken (a)(b): The facility submitted 10 detainee files that included both the Inmate Commitment Summary Report and the Booking Observation Report. The Auditor reviewed the submitted documentation and confirmed that the detainee's initial Screening/classification process and housing assignment was completed in under 12 hours and that the detainees were kept separated form general population until classified in 7 of the 10 submitted files. In addition, the facility submitted electronic training records to confirm that all applicable staff were trained on the new procedure, SOP 2001 "Initial Classification." Upon review of all submitted documentation, the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

(c)(d): SOP 2002 states, "The Classification Coordinator or designee will conduct an interview with all new intakes and complete the Classification Profile Worksheet in the Offender Management System." The auditor observed that the Classification Profile Worksheet is objective and considers whether the detainee has a mental, physical, or developmental disability, the detainee's age, the detainee's incarceration history, criminal history, history of sexual victimization, history of violent offenses, prior institutional violence or sexual abuse, sex abuse offenses, and whether the detainee identifies as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming. However, the screening form does not address the detainee's physical build or the detainee's own concerns about his/her safety, nor is this information asked elsewhere during the intake process.

Does Not Meet (c): The facility conducts initial assessments using an objective screening tool, the Classification Worksheet; however, the screening tool does not include the detainee's physical build and appearance or the detainee's own concerns about his/her safety, nor is it asked elsewhere during the intake process. To confirm compliance, the facility must adjust their process to ensure the detainees physical build and appearance and the detainee's own concerns about his/her safety as required by paragraphs (3) and (9) of subsection (c) of the standard are included in the screening.

Corrective Action Taken (c): The facility submitted 10 detainee files that confirmed that the facility considers physical build and appearance and the detainee's own concerns for their safety by logging in the height and weight of the detainee and by asking the detainee if they are "over-anxious or afraid." In addition, the facility submitted electronic training records confirming that applicable staff have been trained in the new process. Upon review of the submitted documentation, the Auditor now finds the facility in substantial compliance with subsection (c) of the standard.

(e)(f)(g): The Auditor reviewed SOP 2002 that states, "A 60–90-day re-classification is conducted by the Classification Coordinator or designee after the initial classification assessment and when a detainee's behavior reflects the need to be classified." The Auditor also reviewed SOP 1517 that states, "Staff is prohibited from revealing information pertaining to sexual abuse to anyone other than to the extent necessary." The Classification Coordinator confirmed that she and intake staff conduct detainee classification reassessments within the first 30 days, and 60–90-day intervals. The Auditor reviewed

14 detainee files and confirmed that only one detainee was due for a 60–90-day re-classification as required by the standard. A review of the classification document confirmed the re-assessment was completed within the 60–90-day timeframe as required. The PSA Compliance Manager verified that the Classification Coordinator completes the classification reassessments. However, there was no documentation in the detainee victims' files indicating that a reassessment was completed after an incident of sexual abuse. The Classification Coordinator, and the PSA Compliance Manager indicated that detainees are not punished for refusing to answer assessment questions during intake. Also, the Classification Coordinator indicated that sexual abuse risk assessment information is kept in the Offender Management System (OMS) and that only intake staff have access to the information. The PSA Compliance Manager verified PCCF's policy indicating that sexual abuse information is disseminated on a need-to-know basis.

Does Not Meet (e): The facility does not meet subsection (e) of the standard. A review of the two investigative files did not confirm that a reassessment had been completed following the incident of sexual abuse as required by the standard. To confirm compliance, the facility must update their process to ensure that a reassessment is completed at any time when warranted based upon the receipt of additional relevant information or following an incident of sexual abuse or victimization. In addition, the facility must document that all Classification staff are trained on the new procedure. The facility must provide to the Auditor, if applicable, all investigative files of allegations that occurred during the CAP period and the related risk assessments.

Corrective Action Taken (e): The facility submitted SOP 1517 which states, "The classification staff would be responsible for the reassessment of a detainee victim following an incident of sexual abuse." In addition, the facility provided notes from a Mental Health 90-day evaluation, dated 8/29/2022, that confirmed that the detainee was scheduled to be seen by mental health for "New Intake Mental Health Evaluation – 90 Days" and not for a reassessment for sexual victimization or abusiveness. The provided Mental Health Evaluation further confirmed that the detainee reported an allegation of sexual abuse on 7/4/2022, which is 57 days earlier than the scheduled "New Intake Mental Health Evaluation – 90 Days." Although the facility submitted Mental Health notes, the notes confirmed that the meeting was a scheduled 90-day assessment and not to reassess the detainee's risk for victimization or abusiveness as required by the standard. Furthermore, the documentation submitted did not confirm that the classification staff completed a reassessment on a detainee victim following an allegation in alignment with SOP 1517. Upon review of the submitted documentation, the Auditor continues to find that the facility does not meet subsection (e) of the standard.

§115.42 - Use of assessment information
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on interviews with staff and documentation provided. The PSA Compliance Manager indicated that staff makes individualized assessments for housing and classification decisions by asking specific screening questions during intake: mental, physical, or developmental disability; age of the detainee; detainee's previous incarceration; nature of the detainee's criminal history; detainee's convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; and if the detainee has self-identified as having previously experienced sexual victimization; however, the Auditor could not confirm through detainee file reviews or in interviews with the Classification Coordinator that the information from the risk screening is used in determining recreation and other activities or voluntary work assignments. The Classification Coordinator indicated that transgender or intersex detainees are given the opportunity to shower separately from other detainees. The Auditor reviewed a memorandum (dated 11/16/21) from the PSA Compliance Manager indicating there were no transgender or intersex detainees admitted into the facility within the past 12 months. Five Correctional Officers were interviewed by the Auditor; three of the officers indicated that transgender and intersex detainees are provided the opportunity to shower separately and two were unsure of the process. The PSA Compliance Manager reported that all detainees shower alone during the initial assessment process and throughout their stay at PCCF.

Does Not Meet (a)(b): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41. The Auditor could not confirm through detainee file reviews or in an interview with the Classification Coordinator that the information from the risk screening (although, already noted in 115.41 is lacking necessary criteria to be a full risk screening) is used in determining recreation and other activities or voluntary work assignments. To become compliant with subsection (a) of the standard, the updated risk screening tool needs to be utilized so that detainee participation in recreation, volunteer programming and other activities can be properly assessed. In addition, all Intake and applicable staff should be trained in the proper use of the risk screening form when determining the elements of the standard. The facility must provide the Auditor with 10 detainee files to document that the risk screening was considered when determining recreation, programming, and volunteer work. Furthermore, the facility is not in compliance with section (b) of the standard. Although

the facility conducts an initial PREA screening upon intake, the facility was unable to demonstrate, through an interview with the Classification Coordinator, that the information or documentation pertaining to housing decision, recreation, and programming of transgender or intersex detainees are parallel to that of a detainee in general population. In addition, the facility was unable to provide the Auditor with documentation pertaining to the reassessments of transgender or intersex detainees. To become compliant, the facility must update their procedure to include when making assessment and housing decisions for a transgender or intersex detainee, the facility must consider the detainee's gender, self-identification, and an assessment of the effects of placement on the detainee's health and safety. In addition, the facility must include that a transgender or intersex detainee's housing recreation, and programming decisions are reviewed at least twice a year to determining if any threats to safety were experienced by the detainee. If applicable, the facility must provide the Auditor with any transgender, or intersex detainee files and medical records to determine compliance.

Corrective Action Taken (a): The facility submitted 10 detainee files that confirmed that the facility considers physical build and appearance and the detainee's own concerns for their safety by logging in the height and weight of the detainee and by asking the detainee if they are "over-anxious or afraid." In addition, the facility submitted staff training records dated May 29, 2022 – June 4, 2022, entitled "Initial Classification;" however, the facility did not provide any detainee files that confirmed that the facility utilizes the information from the initial risk screening when assessing detainee participation in recreation, volunteer programming, and other activities. Therefore, the facility has not confirmed that the updated practice of utilizing the information from the initial risk screening tool so that a detainee's participation in recreation, volunteer programming, and other activities can be properly assessed has been implemented. Upon review of the submitted documentation, the Auditor continues to find that the facility does not meet subsection (a) of the standard.

Corrective Action Taken (b): The facility submitted a copy of SOP 2001 that confirms the policy has been updated to include the verbiage "when determining housing assignments for transgender or intersex detainees, the facility will consider the detainee's gender, self-identification, and an assessment of the effects of placement on the detainee's health and safety," and "a transgender or intersex detainee's housing recreation, and programming decisions are reviewed at least twice a year to determine if any threats to safety were experienced by the detainee." In addition, the facility submitted electronic training records that confirm all applicable staff have been trained on the updated policy. The facility also submitted a memo, dated 9/2/2022, that states, "Please be advised that no transgender or intersex detainees have been committed to the PCCF during the CAP period." Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsection (b) of the standard.

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

(a)(b)(c): The Auditor reviewed SOP 1101 (Administrative Segregation/Protective Custody) that states, "Involuntary segregated housing/protective custody shall not ordinarily exceed a 30-day period, however, if needed longer, a review will be provided every 30 days if such housing is ongoing or needed." Additionally, SOP 2002 states, "An inmate/detainee who has partially completed a gender change procedure will be placed in administrative segregation pending a review by the facility Doctor. If an inmate/detainee is found to have a mix of female and male genitalia, he/she will be classified max/protective custody for his/her protection. Any transgender inmate/detainee will be housed alone and will recreate alone." However, the policy does not address that transgender or intersex detainees having access to programs, visitation, or counsel. Likewise, neither policy address the use of administrative restrictive housing to protect detainees vulnerable to sexual abuse or sexual assault are restricted to those instances where reasonable efforts have been made to provide appropriate housing and must be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. A review of SOP 1101, in conjunction with the Warden and SDDO interviews, indicates that the policy has not been developed with the ICE ERO Field Office as required by subsection (a) of the standard. In addition, the policies do not describe how an individualized assessment would be made to determine appropriate housing prior to placing detainees into restrictive housing as a last resort of ensuring their sexual safety.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. The facility's SOP 1101 has not been developed in consultation with the ICE ERO Field Office. In addition, SOP 1101 indicates that detainees are sent to administrative restrictive housing or protective custody for no longer than 30 days and that a transgender or intersex detainee would be sent to protective custody automatically. The policy does not describe how an individualized assessment would be made to determine appropriate housing. To confirm compliance, the Auditor requires the facility, in consultation with the ICE ERO Field Office, to update SOP 1101 and their practices to ensure individualized assessments are made to determine appropriate housing and to use administrative restrictive housing as a last resort. In addition, the facility, in conjunction with the ICE ERO Field Office, must update SOP 1101 to include that the transgender or intersex detainee will be housed in administrative segregation only after an individualized assessment to determine appropriate housing. In addition, if applicable, the facility must provide the Auditor with any transgender or intersex

detainee files and medical records to document that the facility properly assessed the detainee prior to assigning the detainee to administrative segregation. The facility is also not in compliance with subsection (c) of the standard. Facility SOP 1101 does not include the verbiage that a detainee in Administrative Segregation due to vulnerability to sexual abuse is afforded access to programs, visitation, counsel, and other services available to general population. To become compliant the facility, in conjunction with the ICE ERO Field Office, must include such verbiage in SOP 1101. The facility must also provide the Auditor with documentation that all applicable staff have been trained in the new policy/practice. In addition, if applicable the facility must provide the Auditor with any detainee's file who has been placed in administrative segregation due to being vulnerable to sexual abuse/assault and, if applicable, the facility must provide the Auditor with any transgender or intersex detainee files and medical records to document that the facility properly assessed the detainee prior to when before assigning the detainee to administrative segregation.

Corrective Action Taken (a)(b)(c): The facility submitted a copy of updated SOP 1101 that includes "individualized assessments are made to determine appropriate housing for transgender and intersex detainees", "the use of administrative restrictive housing is only as a last resort", and "a detainee in administrative segregation due to vulnerability to sexual abuse is afforded access to programs, visitation, counsel, and other services available to general population." In addition, the facility submitted and a memo from the AFOD that confirms that SOP 1101 was updated in consultation with the ICE ERO Field Office. The facility provided electronic training records confirming all applicable staff were trained on the updated policy. In addition, the facility also submitted a memo, dated 9/2/2022, that states, "Please be advised that no transgender or intersex detainees have been committed to the PCCF during the CAP period. Upon review of the submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

(d)(e): The Auditor reviewed of SOP 1101 which states, "The Shift Commander reviews the staff member's incident report pertaining to a detainee's need to be placed into protective custody and completes an administrative segregation form which is forwarded to the detainee within 24 hours. The Assistant Warden reviews all temporary administrative segregations within 72 hours." This policy states "if a detainee has been placed into protective custody, he/she will be afforded the opportunity to have a hearing conducted by the Classification Committee (Classification Coordinator, Shift Commander or designee, and a Treatment Counselor) concerning protective custody placement. Weekly reviews will be conducted by the Committee to determine the need for protective custody. The ICE SDDO will be notified when an ICE detainee's stay in administrative segregation has exceeded 30 days and will also receive a weekly update on all ICE detainees in administrative segregation." However, the standard requires the ICE FOD be notified within 72 hours after the initial placement into administrative segregation based on vulnerability to sexual abuse or assault. The Warden indicated that the facility would notify the ICE Field Office immediately and that protective custody starts at booking depending on the outcome of the PREA intake screening. The auditor reviewed a memorandum (dated 12/19/21) from the PSA Compliance Manager informing there was no detainee placed in protective custody within the past 12 months. According to 10 detainee file reviews, there were no detainees housed in protective custody due to a sexual abuse vulnerability.

Does Not Meet (d)(e): According to SOP 1101, detainees who are placed into protective custody or administrative segregation are afforded the opportunity to have a hearing conducted by the Classification Committee and that such reviews by this Committee will be conducted on a weekly basis. However, subsection (d) of the standard requires that a supervisor conduct, at a minimum, a subsequent review after the detainee has spent seven days in administrative restrictive housing, and every week thereafter for the first 30 days, and every 10 days thereafter. In addition, the policy is not consistent with addressing who is responsible for the subsequent reviews (the Assistant Warden or the Classification Committee) and when such reviews are conducted. Therefore, to become compliant with this subsection of the standard, the facility must update its policy to provide specified timeframes of subsequent reviews and clearly indicate who is responsible for conducting the reviews. Facility policy dictates that the facility notifies the ICE SDDO when an ICE detainee's stay in administrative segregation has exceeded 30 days; however, subsection (e) of the standard requires the ICE FOD be notified within 72 hours after the initial placement into administrative segregation based on vulnerability to sexual abuse or assault. To become compliant the facility must update SPO 1102 to require the facility to notify ICE SDDO within 72 hours after the detainee's initial placement into administrative segregation based on vulnerability to sexual abuse or assault and that the SDDO notifies the FOD within the 72-hour timeframe as required by the standard. In addition, the facility must document that applicable staff have been trained in the updated SOP. Further, if applicable, the facility is to submit confirmation that the ICE FOD had been notified within 72 hours of the detainee being placed in administrative segregation because of being vulnerable to sexual abuse or assault.

Corrective Action Taken (d)(e): The facility submitted a copy of updated Policy 1101 that confirms that the facility added the language requiring "the classification coordinator to conduct subsequent reviews of all vulnerable detainees placed in administrative segregation for their protection and that a subsequent review will be conducted after the detainee has spent seven days in administrative restrictive housing, every week thereafter for the first 30 days, and every 10 days thereafter." The facility also submitted electronic training records confirming all applicable staff have received training on

the updated policy. In addition, the facility submitted a memo, dated 9/2/2022, that states, "Please be advised that no detainees were confined to Administrative Segregation for their protection due to being vulnerable to sexual abuse during the CAP period." Upon review of the submitted documentation the Auditor now finds the facility in compliance with subsections (d) and (e) of the standard.

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

(a)(b)(c)(d)(e)(f): The Auditor reviewed SOP 1605 (Inmate/Detainee Grievances) which states, "Detainees may file a grievance related to sexual abuse." The PCCF Detainee Handbook indicates, "A detainee may file a complaint of sexual abuse by calling or writing the DHS OIG. A detainee who perceives an immediate threat to their health, safety or welfare may submit a sensitive or emergency grievance by submitting through housing unit kiosk or if in restrictive/segregated housing, the emergency grievance may be written and submitted directly to the Shift Commander. If the request does not receive a response within one hour, an alert is sent to the Warden and both Assistant Wardens. Detainees may submit a medical grievance through the housing unit kiosk but that detainees in restrictive housing may obtain a medical grievance form and envelope from the housing unit officer to submit a medical grievance. The Grievance Committee will respond to a detainee's grievance in writing within 10 business days of the date the grievance was received. A facility nurse will provide a written response pertaining to a medical grievance within five days of receipt. Detainees are provided assistance if needed when preparing for a grievance. Grievance preparation and submission assistance will be provided to detainees who are not fluent in English, need interpretive services, are disabled or those needing general assistance." The policy does not indicate that detainees are allowed to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging a formal complaint; that the facility must respond to a detainee's appeal of his/her grievance within 30 days; a detainee will be issued a decision on the grievance within five days of receipt; and that PCCF must send all grievances related to sexual abuse and the facility's decision with respect to such grievances to the appropriate ICE FOD at the end of the grievance process. According to the PCCF Detainee Handbook, "to obtain assistance, the detainee must use the housing kiosk or ask the housing unit counselor." SAAPI pamphlets and ICE Detainee Handbooks inform detainees of multiple ways to report sexual abuse which includes third-party and anonymous reporting. Five Correctional Officers were interviewed and when asked, four stated they would accept a sexual abuse report made through the grievance system and that the detainees use the kiosks on their housing units to submit grievances. Eight detainees confirmed they could report a sexual abuse allegation to any staff member, verbally and through the grievance system. While at PCCF, the Auditor initiated a "test" grievance through the kiosk to gather an understanding of PCCF's grievance system. The PSA Compliance Manager provided the Auditor with an email receipt specifying the date, time, offender, and brief synopsis of the "test" grievance. The email receipt also indicated that the grievance was sent to the Warden, Assistant Warden, and facility investigators. The Auditor reviewed two detainee investigative file reviews and did not observe any documentation supporting that the facility provided the detainee with a grievance response within five days.

Does Not Meet (a)(e): Although the facility's policy indicated that detainees may file a grievance relating to sexual abuse, PCCF was unable to provide supporting information permitting a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. SOP 1605 states that "the Grievance Committee responds to the detainee grievances in writing within 10 days;" however, the subpart of this standard requires the facility to provide a response to a grievance of sexual abuse within five days. Furthermore, review of the two detainee investigative files, both of which were initially reported to the facility through the grievance process, lacked documentation supporting a response within five days. Therefore, the Auditor is unable to determine compliance with this subpart of the standard. To confirm compliance, the facility must update policy and change its practice to reflect that a detainee will be issued a decision on the grievance within five days of receipt. In addition, SOP 1605 must be updated to include the verbiage that allows the detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging a formal complaint, the facility must respond to a detainee's appeal of his/her grievance within 30 days, and that PCCF must send all grievances related to sexual abuse and the facility's decision with respect to such grievances to the appropriate ICE FOD at the end of the grievance process.

Corrective Action Taken (a)(e): The facility submitted a copy of updated SOP 1605 that contains the verbiage that allows, "the detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging a formal complaint, and the facility must respond to a detainee's appeal of his/her grievance within 30 days." In addition, updated SOP 1605 also requires the Grievance Coordinator to investigate and respond to the detainees sexual abuse allegation grievance within five days of the date the grievance was received. The facility also provided electronic training records that confirm applicable staff have been trained on the updated procedure. In addition, the facility submitted a memo dated 9/2/2022 that states, "Please be advised that there were no detainees who filed a grievance alleging sexual abuse during the CAP period." Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsections (a) and (e) of the standard.

§115.53 - Detainee access to outside confidential support services
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d): The Auditor reviewed SOP 1517 and the PCCF Detainee Handbook indicating VIP is written into the facility's policies to provide detainee victims of sexual abuse with outside confidential support services. A review of SOP 1517 indicated "medical staff informs detainees, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." PCCF entered into a MOU with VIP on 11/04/21 which allows VIP to provide "certified crisis counselors, advocacy services, confidential support services, and accompaniment in court proceedings to detainee sexual assault victims." The Auditor observed VIP flyers, which included VIP address and telephone number, posted throughout the housing units. VIP information is in the PCCF Detainee Handbook but does not include an address or phone number. According to the PCCF Handbook, the VIP phone number and address are on detainee tablets. The PSA Compliance Manager reported that the facility informs detainees about VIP services through detainee tablets and flyers posted on the housing unit bulletin boards. The PSA Compliance Manager reported that PCCF contacts VIP to provide emotional support services to detainee victims of sexual abuse. During the onsite audit, the Auditor confirmed that the tablets contained the phone number and address of VIP but did not advise detainees of the extent to which such communications between detainees and VIP will be monitored and reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. In addition, the Auditor contacted VIP and confirmed that they would provide the services as required by the standard.

Does Not Meet (d): The Auditor was unable to confirm compliance with subpart (d). To confirm compliance, the Auditor recommends that the facility include in the PCCF handbook the extent to which such communications will be monitored, and to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Corrective Action Taken (d): The facility submitted a copy of the updated facility detainee handbook that included the extent to which communications between VIP and the detainee will be forwarded to authorities in accordance with mandatory reporting laws. Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsection (d) of the standard.

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

(a)(b)(c)(d): The Auditor reviewed SOP 1517 that states, "Security staff are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in writing to the Shift Commander and non-security staff to immediately notify the Shift Commander and their Department Head immediately. Staff is prohibited from revealing information about sexual abuse to anyone other than to the extent necessary. If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws." Three Correctional Officers were asked during their interview when they would report an incident of sexual abuse. All three officers reported they would immediately report to the Shift Commander if they received a detainee's report of sexual abuse. The PSA Compliance Manager and the Warden verified that staff must immediately report sexual abuse. The Auditor confirmed through observation and staff interviews that there are no juveniles housed at PCCF. The Auditor could not confirm during interview the facility's obligation when a sexual abuse allegation involves a vulnerable adult.

Does Not Meet (a)(d): The facility is not in compliance with subsections (a)(d) of the standard. A review of facility SOP 1517, in conjunction with staff interviews, could not confirm that the facility provides staff with a method to which they can report an incident of sexual abuse outside the chain of command; and therefore, the facility is not in compliance with subsection (a) of the standard. In addition, interviews with staff could not confirm their awareness of how to report an allegation of sexual abuse as required under mandatory reporting laws, therefore, making the facility not compliant with subsection (d) of the standard. To become compliant with subsection (a) of the standard, the facility must update SOP 1517 to include a method to which staff can report an incident of sexual abuse outside the chain of command and document that all staff have been trained on the updated policy. To become compliant with subsection (d) of the standard, the facility must train all applicable staff on the Pennsylvania mandatory reporting laws and their obligation to report an incident of sexual abuse involving a vulnerable adult to the designated State or local agency. If applicable, the facility must submit documentation that the designated State or local agency under applicable mandatory reporting laws was contacted because of a vulnerable adult being the victim of a sexual abuse or assault.

Corrective Action Taken (a)(d): The facility submitted a copy of updated SOP 1517 to include the verbiage, "An allegation of sexual abuse with an alleged victim under the age of 18 or be considered a vulnerable adult will be reported to designated state of local service agencies," and "all staff may report an incident of sexual abuse outside of the chain of command to the (VIP) Victim's Intervention Program" with the phone numbers to both agencies included. In addition, the facility submitted a memo from the FOD confirming that the Agency reviewed and approved SOP 1517 and electronic training records confirming that all applicable staff were trained on the updated policy. The facility also provided a memo dated 9/2/2022 that states, "Please be advised that there were no detainees who were classified as a vulnerable adult who filed a sexual abuse allegation during the CAP period." Upon review of all submitted documentation, the Auditor now finds the facility in compliance with subsections (a) and (d) of the standard.

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

(a)(b): The Auditor reviewed SOP 1517 that states, "If security staff becomes aware of alleged sexual abuse, the detainee victim and abuser must be separated, immediately notify Shift Commander and medical, secure the crime scene, take photographs, or video recordings of the scene, ensure the detainee victim does not shower, wash, brush teeth, urinate, defecate, drink, eat, or change clothing. Non-security staff first responders will ensure the detainee victim does not take any actions that could destroy physical evidence and notify the Shift Commander and their Department Head immediately." The Auditor reviewed a memorandum (dated 11/19/21) from the PSA Compliance Manager stating there were no allegations of sexual abuse received from a non-security first responder staff within the past 12 months. The Behavioral Health Director, PSA Compliance Manager, Training Supervisor, kitchen staff, and Correctional Officers indicated they were knowledgeable of their first responder duties. During the two investigative file reviews, the Auditor confirmed that one of the detainee victims was separated from the alleged staff perpetrator; however, there was no indication of such separation or any other first responder duties in the other investigative file.

Does Not Meet (a): The Auditor was unable to determine compliance with subsection (a) of the standard. The facility was unable to provide confirmation of the first responder duties completed in one of the sexual abuse allegations. To confirm compliance, the facility must provide documented refresher training regarding their responsibilities as first responders. In addition, if applicable, the facility must provide the Auditor with all investigation files that result from allegations of sexual abuse to confirm that staff are knowledgeable in their duties as first responders.

Corrective Action Taken (a): The facility submitted three sexual abuse allegation investigation files; however, two files did not rise to involving first responder duties. The third file reviewed included the separation of the alleged staff perpetrator from the detainee and an offer to bring the detainee to medical for evaluation, which he refused, and the facility documented with a medical refusal form. Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.66 - Protection of detainees from contact with alleged abusers
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

The Auditor reviewed SOP 1517 that states, "An employee may be relieved of his/her duties if deemed necessary and that employee may be suspended pending the outcome of the investigation. Staff will be removed from all duties requiring detainee contact with detainees pending outcome of an investigation." The Warden and PSA Compliance Manager confirmed the detainee victim would be separated from the alleged staff perpetrator by removing staff from any contact with the detainee victim pending the outcome of investigation. However, the Auditor conducted two investigative file reviews of staff-on-detainee sexual abuse and found that only one staff was removed and prohibited from having any contact with the detainee victim pending outcome of the investigation. In addition, there was no supporting documentation or policy provided regarding detainee protection from contractor or volunteer perpetrators.

Does Not Meet: The Auditor was unable to determine compliance with this standard. In review of the two staff-on-detainee investigative files, only one file indicated staff had been removed from having contact with the detainee victim pending outcome of the investigation. In addition, the facility must demonstrate, if applicable, that staff, volunteers, or contractors were removed from duties during the investigation process by providing the Auditor copies of investigation files that occurred during the CAP period. Finally, the facility must provide documented training of all applicable staff in the section of policy SOP 1517 that requires any staff suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of the investigation as determined by ICE.
Corrective Action Taken: The facility submitted a staff-on-detainee sexual abuse allegation investigation file that confirmed that the staff person was removed from all detainee contact pending the outcome of the investigation. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with standard 115.66.

§115.67 - Agency protection against retaliation
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): The Auditor reviewed SOP 1517 that prohibits any retaliatory action against "any detainee victim of sexual harassment or sexual misconduct and against any staff who reports or cooperates with such investigation. Protection measures such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations." The policy also states, "The Assistant Wardens and Shift Commanders/Department Heads monitor to see if any changes may suggest retaliation and that such issues will be addressed during the weekly classification meeting by reviewing disciplinary reports, housing unit changes, and program changes. Staff is monitored by the Assistant Wardens in their staff performance appraisals and staff reassignments." In one section, policy states the Assistant Wardens and Shift Commanders are responsible for retaliation monitoring. However, in the investigations section, policy indicates the PSA Compliance Manager is responsible for retaliation monitoring for at least 90 days. The Auditor reviewed a memorandum (dated 01/27/21) from the PSA Compliance Manager stating that he completed a 90 day follow up with a detainee victim of sexual harassment and determined there was no indication of retaliation. The Warden indicated retaliation monitoring is conducted for at least 90-days, and "PCCF has a Special Needs Committee assigned to review housing issues, disciplinary, any other issues after reporting." In addition, the Warden indicated that he also follows up with the detainee victim to ensure there is no retaliation and advised that sometimes the PSA Compliance Manager is contacted during the Committee meetings for more information gathering. The Auditor conducted a file review of two sexual abuse allegations and neither file indicated 90-day retaliation monitoring was completed.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. The Auditor conducted a file review of two sexual abuse allegations and neither file confirmed that the required 90-day retaliation monitoring was completed. To confirm compliance, the facility must develop a process to ensure retaliation monitoring is conducted and documented as soon as an allegation is reported and must provide training to staff responsible for monitoring for retaliation. The facility must provide the process established, documented staff training, and examples of all retaliation monitoring completed during the CAP period (if available) for compliance review.

Corrective Action Taken (c): The facility submitted updated SOP 1517 that confirms that the facility updated their procedures to reflect that "retaliation monitoring is conducted and documented as soon as an allegation is reported, continues for at least 90 days following the incident, and shall continue beyond 90 days if the initial monitoring indicates a continuing need and that the procedures include specifically what should be monitored, including but not limited to, detainee disciplinary reports, housing or program changes, or negative performance reviews of reassignments of staff and that the any issues will be addressed during the weekly classification meeting." In addition, the facility submitted electronic training records confirming applicable staff have been trained on the updated procedure. The facility submitted a memo dated 9/2/2022 that stated, "There were no detainees that required retaliation monitoring during the CAP period;" however, the facility had an allegation of sexual abuse during the CAP period, and therefore, the alleged victim required facility monitoring. As the facility did not provide documentation that the detainee victim who reported an incident of sexual abuse during the CAP period was monitored by the facility for retaliation, the Auditor finds that the facility continues to not meet subsection (c) of the standard.

§115.71 - Criminal and administrative investigations
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a): The Auditor determined compliance with the subpart of the standard based on review of SOP 1517 that states, "All allegations of sexual abuse will be investigated promptly, thoroughly, and objectively by specially trained investigators. If the allegation is against medical and mental health staff, investigators, or the facility administrator the highest-ranking staff member not involved shall investigate." The Auditor conducted two investigative file reviews and found that both sexual abuse allegations had undergone an administrative investigation. The two investigative file reviews reflected that the victim, the abuser, and witnesses were interviewed, a description of evidence was indicated, and a comprehensive report was completed.

Does Not Meet (a): The Auditor was unable to determine compliance with this subpart of the standard. The current policy reflects that anyone, specially trained or not, can conduct an investigation into sexual abuse involving the aforementioned staff. In addition, a review of the curriculum confirms the investigator has not received training on cross agency coordination. To confirm compliance, the Auditor recommends the facility update the policy to reflect if the allegation is against medical or mental health staff, an investigator, or the facility administrator, the highest ranking specially trained investigator will conduct the interview. In addition, similar to 115.34, the facility must update their lesson plan to

reflect cross agency coordination as required by the standard and provide the Auditor with updated lesson plan. The facility must provide the Auditor with documentation that the assigned facility investigator received training on the updated lesson plan.

Corrective Action Taken (a): The facility submitted updated SOP 1517 which confirms it contains the verbiage, "if the allegation is against medical or mental health staff, investigators, or the facility administrator the highest ranking specially trained investigator will conduct the interview." The facility provided the Auditor with their updated PREA Investigator lesson plan that confirms that the curriculum included a section on Cross Agency Coordination. In addition, the facility submitted training documentation entitled, "PREA Cross Training for PREA Investigators," which confirmed all facility investigators received the required training. Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsection (a) of the standard.

(b)(c)(e)(f): The Auditor reviewed SOP 1517 that states, "Administrative investigations will include an effort whether staff actions or failures to act contributed to the abuse. PCCF's investigators are responsible for investigating all allegations of sexual abuse and sexual harassment. All allegations will be investigated promptly, thoroughly, and objectively by facility investigators who received special training in sexual abuse investigations in confinement settings. The facility investigators will gather and preserve direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data. They will interview the alleged victims, suspected perpetrators and witnesses and review prior complaints and reports of sexual abuse involving the suspected perpetrator. If criminal activity is determined by the facility investigator, the PSP will be contacted. All information will be forwarded to the PSP for possible criminal charges." Should it be determined such allegation is of a criminal nature, the allegation will be referred to PSP. PCCF's investigators shall preserve 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; and 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." Also, SOP 1517 states, "The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation." In an interview with the PSA Compliance Manager, it was indicated that the facility would remain informed about the progress of the outside agency's investigation progress; however, the PSA Compliance Manager could not outline a facility practice that would be followed to confirm that the facility was informed of the outside agency's investigation progress. The PSA Compliance Manager further stated that the investigation of sexual abuse would continue even if a detainee victim or abuser is no longer housed at PCCF. The Warden and PSA Compliance Manager verified that an administrative investigation is conducted on all allegations of sexual abuse in addition to any criminal investigations. The Warden indicated that a review of the incident is conducted during incident reviews. The two investigative file reviews reflected that the victim, the abuser, and witnesses were interviewed, a description of evidence was indicated, and a comprehensive report was completed. As both investigations deemed to not be criminal in nature the cases were not referred to the PSP.

Does Not Meet (f): The facility is not in compliance with subsection (f) of the standard. In an interview, the PSA Compliance Manager could not articulate a facility practice that would confirm that the facility would be informed of the outside agency's progress in an investigation of sexual abuse. To become compliant, the facility must develop a practice to include specifics as to what the Investigator's responsibility is in determining the progress of an outside agency sexual abuse investigation. In addition, the facility must document that all applicable staff have been trained in the new practice. The facility must, if available, provide the Auditor with any investigation files that were referred to the PSP to confirm that the facility was kept informed of the progress of the ongoing investigation.

Corrective Action Taken (f): The facility submitted a copy of updated SOP 1517 that states, "The facility investigator will contact the PSP Investigator bi-weekly to attain updates on the status of sexual abuse investigations." The facility also submitted a memo from the AFOD confirming that SOP 1517 reviewed and approved by the Agency and electronic training records that confirm applicable staff were trained in the updated policy. In addition, the facility submitted a memo dated 9/2/2022 that stated, "There were no incidents of sexual abuse that were referred to the PSP during the CAP period." Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsection (f) of the standard.

§115.76 - Disciplinary sanctions for staff
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d): The Auditor reviewed SOP 2401 and SOP 1517 which state, "Termination is the presumed sanction for staff when their investigation of sexual abuse has been substantiated." The policies also state, "PCCF will report all employee terminations and resignations as a result of violating PCCF's sexual abuse policy to any relevant licensing bodies, to the extent known, and PSP if of a criminal nature." A review of both policies indicate that neither were reviewed and approved by the Agency, nor do they contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards." In addition, neither policy indicates that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse or a detainee by a staff member, contractor, or volunteer." The Auditor reviewed a memorandum (dated 11/18/21) from the PSA Compliance Manager stating there were no staff resignation, termination, or discipline for violating the facility's policy on sexual abuse within the past 12 months. In addition, the Warden stated staff would be removed, placed on administrative leave, and even terminated depending on the outcome of investigation. The Auditor conducted two investigative file reviews of sexual abuse allegations against staff and found that both investigations concluded with an unfounded finding.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of both policies indicate that neither were reviewed and approved by the Agency, nor do they contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards." In addition, neither policy indicates that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." To become compliant with subsections (a) and (b), the facility must update SOP 2401 and SOP 1517 to include the required verbiage of the standard. In addition, if applicable, provide investigation files that confirm a staff member was disciplined in accordance the standard 115.76 after an incident of substantiated sexual abuse.

Corrective Action Taken (a)(b): The facility submitted copies of SOP's 2401 and 1517 that contain the verbiage that "any employee found guilty of sexual abuse with a detainee will be terminated from employment." The facility also submitted a memo dated 9/2/2022 that states, "There were no substantiated allegations of sexual abuse that involved an employee that occurred during the CAP period." As termination is a greater penalty then removal from federal service, the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

§115.78 - Disciplinary sanctions for detainees
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(e)(f): The Auditor reviewed SOP 1517 that states, "A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The Auditor confirmed through investigative file reviews that there was no detainee disciplined for making a sexual abuse report within the past 12 months. However, SOP 1517 did not include verbiage supporting a detainee would not be disciplined for sexual contact with staff unless there is a finding that the staff member did not consent to such contact, nor did interviews support this practice would be adhered to.

Does Not Meet (e): The Auditor was unable to determine compliance with this subpart of the standard. The facility was unable to provide documentation indicating the facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. To confirm compliance, the Auditor recommends the facility to update policy reflecting this requirement.

Corrective Action Taken (e): The facility provided the Auditor with an updated SOP 1517 that contained the verbiage, "The inmate/detainee shall not be disciplined for sexual contact with staff unless there is finding that the staff member did not consent to such contact." In addition, the facility submitted a memo from the Assistant Field Office Director (AFOD) stating that the Agency has received, reviewed, and approved updated policy 1517. Upon review of the submitted the documentation, the Auditor now finds that the facility is in compliance with subsection (e) of the standard.

§115.82 - Access to emergency medical services
Outcome: Does not Meet Standard
Notes:

(a)(b): The Auditor determined compliance with these subparts of the standard based on review of SOP 1517 and PCCF PrimeCare Policy C, J-F-06 stating "detainee victims of sexual abuse have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and that emergency medical treatment services provided to the victim shall be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." In interviews with the Vice President of PrimeCare, the Regional Medical Director, and the Behavioral Health Director, all indicated that detainee victims of sexual abuse while detained are offered tests for sexually transmitted infections and that treatment services are provided to detainee victims at no cost regardless of whether the victim names the abuser or cooperates with the investigation. The Auditor reviewed a memorandum (dated 11/19/21) from the PSA Compliance Manager stating there was no emergency medical treatment provided to a detainee as a result of sexual abuse within the past 12 months. The Auditor reviewed two investigative files and determined the detainees were not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. Following the incidents, one detainee stated he did not need medical services; and therefore, was not taken to medical for assessment. The review of the second investigative file indicates that the detainee was not taken to medical for treatment after the incident. In an interview with the second detainee, he indicated that he was seen by Mental Health but did not report that he was seen by medical.

Does Not Meet (a): The facility is not compliant with section (a) of the standard. The Auditor reviewed two investigative files and determined that neither detainee was provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. In one incident, the detainee refused medical treatment, and in the second incident there is no indication that the detainee was offered medical treatment, and therefore the Auditor could not confirm either detainee was taken to medical for assessment. However, the standard requires timely, unimpeded access to medical, where the refusal of services can be made directly to medical staff who would be the appropriate individuals to assess needs for medical services, and that assessment or declination of assessment documented in the detainee's medical file. To become compliant, the facility must develop a protocol that ensures detainee victims are afforded timely, unimpeded access to medical and mental health services after every reported incident of sexual abuse. In addition, the staff must be trained on the new protocol and the training must be documented.

Corrective Action Taken (a): The facility submitted updated, SOP 1517 that states, "The Shift Commander shall ensure the victim received timely unimpeded access to emergency medical treatment and crisis intervention services." In addition, the facility submitted electronic training records that confirm that applicable staff were trained on the new procedure. The facility submitted a memo dated 9/2/2022 that states, "There have been no instances of sexual abuse during the CAP period", however, as confirmed by the ERAU Team Lead the facility did have an allegation of sexual abuse during the CAP period, and therefore, the facility was required to provide documentation to the Auditor to confirm the detainee received timely unimpeded access to emergency medical treatment and crisis intervention services as required by the standard. The facility provided mental health notes dated the day of the incident that confirmed that mental health provided crisis intervention services as required by subsection (a) of standard; however, the facility did not provide documentation to confirm the detainee received unimpeded access to emergency medical treatment. Upon review of the submitted documentation, the Auditor finds that the facility continues not to meet subsection (a) of the standard.

§115.86 - Sexual abuse incident reviews
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on review of SOP 1517 which states, "PCCF shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the agency PSA Coordinator. PCCF's review team consists of the Warden, Assistant Wardens, PSA Compliance Manager, facility investigators, and medical staff. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility." The Auditor reviewed memorandum (dated 11/19/21) from the PSA Compliance Manager stating there were no cases of sexual abuse to recommend or implement changes within the past 12 months. The PSA Compliance Manager reported that an incident

review is immediately conducted after each sexual abuse investigation has been completed. The Auditor conducted two investigative file reviews of sexual abuse allegations reported at PCCF and found that an incident review was conducted within 30 days after the conclusion of the investigation. Also, the Auditor reviewed a memorandum (12/15/21) from the PSA Compliance Manager stating an Annual Review of two PREA related complaints was conducted by the Warden, SDDO, and the PREA Coordinator. According to the memorandum, the necessity for surveillance cameras, facility modifications, and staffing levels were discussed, and they determined there were no changes or modifications needed at the time. The PSA Compliance Manager further confirmed during interview that PCCF conducts an annual review of the facility's sexual abuse investigations and incident reviews; however, the facility was unable to provide documentation supporting the review was sent to the FOD and Agency PSA Coordinator.

Does Not Meet (c): The facility is not compliant with subsection (c) of the standard. A review of the annual review, in conjunction with the Warden and PSA Compliance Manager interviews, could not confirm that the facility sent the review to the FOD and the Agency PSA Coordinator. To become compliant, the facility must send the annual review to the FOD and Agency PSA Coordinator and provide documentation that it was sent.

Corrective Action Take (c): The facility submitted an annual report for 2021. In addition, the facility provided a memo from the AFOD confirming the facility sent the annual review to the FOD and Agency PSA Coordinator. The facility is now compliant with subsection (c) of the standard.

Choose an item.

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 October 20, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) October 20, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) October 21, 2022
Program Manager's Signature & Date