PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	7/20/2021	**To:**	7/21/2021
AUDITOR INFORMATION			
Name of auditor:	Margaret L. Capel	**Organization:**	Creative Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(479) 521-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	ICE/ERO San Antonio Field Office
Field Office Director:	Jose M. Correa, Sr.
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1777 NE Loop 410 Floor 15 San Antonio, TX 78217
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:	Port Isabel Detention Center		
Physical address:	**279914 Buena Vista Boulevard, Los Fresnos, TX 78566**		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	(956) 547-1700		
Facility type:	SPC		
PREA Incorporation Date:	3/18/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(956) 547-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(956) 547-(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 Prison Rape Elimination Act (PREA) audit of Port Isabel Detention Center (PIDC) (also known as the Port Isabel Service Processing Center) in Los Fresnos, Texas was conducted July 20-21, 2021, by, U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Margaret L. Capel, Lead Auditor, and (b) (6), (b) (7)(C) for Creative Corrections, LLC. The Lead Auditor was provided guidance and review during the audit report writing and review process by the Immigration Customs and Enforcement (ICE) PREA Program Manager, (b) (6), (b) (7)(C) and Assistant ICE PREA 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 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. This is the second DHS PREA audit of the facility.

The PIDC has a design capacity of 1,200 and houses male detainees exclusively. The average detainee population for the last 12 months was reported as 1,054. The average time in custody is reported as 14 days. The top three nationalities of the detainee population are Ecuadorian, Mexican, and Cuban. The facility does not house females, juveniles, or family units.

The ICE PREA audit was originally scheduled for September 22-24, 2020, and was postponed due to the COVID -health pandemic. The audit was changed to a contingency audit. ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g., a health pandemic. The process was divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. Approximately four weeks prior to the contingency audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and Document Request, DHS Immigration Detention Facilities form, in folders for ease of auditing. All documentation, policies, and the PAQ was reviewed by the Lead Auditor and/or the second Auditor. During the Pre-Audit phase, the Auditors completed a review of submitted documentation to include the Pre-Audit Questionnaire (PAQ), facility and agency's policies, detainee detention files, investigative files, and personnel files for staff, contractors, and volunteers. The Auditors requested and reviewed eight employee personnel records, ten employee training files, eight detainee medical records, seven detainee files, and five investigation files.

The second phase, Remote Interviews, was conducted on September 29 through October 1, 2020, consisting of interviews with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers. The population on the first day of the Remote Interview phase was 220. The remote interviews were divided between the Lead Auditor and the second Auditor. The second Auditor was assigned the responsibility of interviewing detainees from targeted categories and random selection. There were 27 randomly chosen detainees interviewed. The Auditor interviewed 23 detainees with limited English proficiency (LEP), with 1 detainee that could not read, and 4 detainees who spoke English. The Auditor used Language Services Associates, provided through Creative Corrections LLC., for interpretation assistance. There were 12 randomly selected security staff interviewed from each of the 3 shifts. Specialized interviews included the Acting Facility Administrator, the AhtnaSTS Project Manager, ICE PSA Compliance Manager, Classification Supervisor, medical staff (3), mental health staff (2), staff first responders (3), Grievance Coordinator, investigators (3), contract employees (6), Human Resource Administrator, Training Coordinator, intake staff (6), and volunteers (2). With the exception of the volunteer interviews, interviews were conducted through a conference line established between the Auditor and the facility. The Pre-audit documentation review and the Remote Interview phase was completed on October 1, 2020.

The third phase, the On-Site Audit, was conducted on July 20-21, 2021, after officials determined the environment was safe for federal and facility staff as well as detainees and Auditors to conduct the on-site phase of the audit. This phase mirrors a traditional PREA audit with a facility tour, observation of facility practices, and follow-up from the prior phases, as needed. Prior to the on-site visit, the Lead Auditor provided a listing of the issues cited in the provisional report which would be addressed at the facility. This listing included documents and interviews to be conducted on-site. The On-site phase of the audit began with communications between the Lead Auditor and (b) (6), (b) (7)(C), ICE/OPR/ERAU Team Lead, to determine logistics and to set a schedule for the on-site visit of PIDC. The audit review period became August 2019 to July 19, 2021.

The facility had six allegations reported during the audit period. The Lead Auditor reviewed five investigations from the audit period of August 2019 to October 1, 2020, during the pre-audit documentation review phase and one during the on-site phase which occurred between the pre-audit documentation phase and the on-site visit. All the allegations were detainee-on-detainee. The ERAU spreadsheet reflected five allegations. The difference was one case the facility did not report to Joint Intake Center (JIC). The contract PREA investigator/contract PSA Compliance Manager stated he investigated the allegation and found it was "horseplay" and he determined the allegation to be unsubstantiated, so it was not reported to the JIC. A Sexual Abuse Incident Review Board was not held for this investigation. Of the other five investigations, four were closed investigations and one was still open. The investigative outcomes for the four cases were three unsubstantiated and one was substantiated. Sexual abuse incident reviews were conducted for each closed investigation. There were no recommendations by the Sexual Abuse Incident Review Board for any of the incidents. The facility utilizes Office of Professional Responsibility (OPR) ICE investigators to complete investigations. Criminal investigations are referred to the Cameron County Sheriff's Office (CCSO). One case was referred to the CCSO, but the detainee declined to pursue criminal charges.

On Tuesday July 20, 2021, before the tour, the lead Auditor held an in-briefing with the agency and facility staff in the conference room at the facility. Attending the entrance briefing were:

- (b) (6), (b) (7)(C), Team Lead, Inspections and Compliance Specialist, ICE, OPR (ERAU) (Via Conference line)
- Margaret L. Capel, Lead Auditor, Creative Corrections
- (b) (6), (b) (7)(C) Auditor, Creative Corrections
- (b) (6), (b) (7)(C) Officer in Charge (OIC), ICE
- (b) (6), (b) (7)(C) PSA Coordinator, Supervisory Detention and Deportation Officer (SDDO), ICE
- (b) (6), (b) (7)(C) Assistant Health Services Administrator (AHSA), ICE Health Service Corps (IHSC)
- (b) (6), (b) (7)(C) Contract Investigator and Prevention of Sexual Assault (PSA) Manager, AhtnaSTS
- (b) (6), (b) (7)(C) Quality Control Manager, Compliance Office, AhtnaSTS
- (b) (6), (b) (7)(C) Chief of Security (COS), AhtnaSTS
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) SDDO, ICE

The Team Lead explained the three phases of the contingency audit process. The Lead Auditor confirmed that no detainees had requested to speak with the Auditors and asked to be notified if a detainee requested to speak to an Auditor. She asked if there were any issues that the Auditors needed to be aware of prior to the facility tour. The PSA Compliance Manager explained, there were several housing areas on "cohort" status, which means the detainee was newly received or had possibly been exposed to COVID-19, and although the tour group would not enter these housing areas the Auditors would be able to view most of these housing areas from the large windows. Facility staff explained there were no cross-gender searches conducted during the audit period. There were no judicial findings of inadequacy. The facility stated they remain compliant with American Correctional Association (ACA), Performance-Based National Detention Standards (PBNDS) and Office of Detention Oversight (ODO) requirements. At the time of the on-site audit phase, the facility's count was 646 with most detainees staying an average of 14 days, according to the PSA Compliance Manager. The Lead Auditor explained the audit team would return to the conference room following the tour to discuss their observations and any issues noted from the tour. She asked to be informed if a new detainee arrives as one of the Auditors will be observing the intake process. The Auditors will meet with the facility administration at the end of each day to discuss any issues or concerns.

The Auditors toured all areas of the facility accessible to detainees to include each housing area (not on cohort status), and Central Control. Auditors did not see a notice of the PREA on-site visit posted in any of the toured areas. The Auditors found each housing area and the Special Management Unit (SMU) had the required PREA postings (DHS-prescribed Sexual Assault Awareness notice, ICE Zero-Tolerance poster, Safe Hotline poster, and the Sexual Abuse and Assault Prevention and Intervention Program Coordinator poster with the name of the PSA Compliance Manager). The housing areas afforded detainees privacy while changing clothing, showering, and perform bodily functions. Unannounced rounds were checked in each housing area and Auditors found rounds are consistently made at an irregular basis on day and night shifts. The Auditor checked the detainee phones in the housing areas and found the Detainee Reporting Information Line (DRIL), Joint Intake Center (JIC), and Office of Inspector General (OIG) operators were willing to accept anonymous reports of sexual abuse.

Central control officers are responsible for monitoring doors and cameras, among other duties. The Auditor reviewed camera footage in several housing areas to include medical. (b) (7)(E) Facility maintenance staff corrected this deficiency on-site by providing a blackout area on the control room monitor of the toilet in these cells. The Auditors checked the monitor and found the camera view afforded the required privacy. The facility provides contact and non-contact visitation. The visitation areas had PREA informational postings visible to visitors. The religious service area, interview rooms, and attorney visitation rooms afforded confidentiality but provided visibility into the office areas.

The intake and sallyport areas had the required PREA postings prominently displayed. ICE National Detainee Handbooks were available in Arabic, Haitian Creole, Simplified Chinese, Spanish, and English. Intake staff were knowledgeable about how to print copies of the remaining six languages available. If the ICE National Detainee Handbook is not available in a detainee's language or the detainee is disabled, intake staff read designated pages from the handbook to the detainee through an interpreter. The intake shower area is equipped with a curtain and is not visible by camera. The medical area provides a physician or nurse practitioner every day until 7:00 p.m. The medical area is equipped with four negative pressure rooms. Detainees on suicide precaution status are placed in suicide precaution cells and continually observed directly by a same sex officer as well as camera monitoring. There were no PREA related concerns noted in the laundry area, court rooms, or program areas. The food service area is being replaced and the new food service area is due to be completed and ready for occupancy within a couple of weeks. The existing food service area has many blind spots, that presented safety concern challenges for the facility. (b) (7)(E) (b) (7)(E)

Following the facility tour, the Auditors began interviews with staff and detainees and conducted file and documentation review. The Lead Auditor met with the PSA Compliance Manager and contract Quality Control Manager throughout the on-site visit to review each area of concern by standard. The new PSA Compliance Manager had only been in his position for approximately three months and was not present for the exit interview conducted following the Remote Interview phase.

The Auditor interviewed three randomly selected LEP detainees during the on-site audit. There were no additional targeted detainees for specialized interviews at the facility at the time of the on-site visit. The Auditors conducted several informal discussions with staff to include medical and mental health staff (2), intake staff (3), Human Resource staff (2), Training Administrator, COS, Contract Quality Control Manager, ICE PSA Compliance Manager, Contract investigator/PSA Compliance Manager, Grievance Officer, former ICE PSA Coordinator, Food Service Manager, and 10 detention officers. The Auditors reviewed detainee detention files (4), an investigation file, and re-reviewed the employee personnel files (8) and training files (10) for further information.

On Wednesday, July 21, 2021, an exit briefing was conducted. The Team Lead explained what would occur regarding the audit process following the on-site visit. She further stated the Auditor may need to request additional information after review of the tour notes, file reviews, and interviews. The Lead Auditor reported all staff were professional and responsive and knowledgeable about their duties. It was clear to the Auditors that the facility is very responsive to any concerns related to PREA and it is apparent PREA is a priority at this facility. Both Auditors thanked the facility staff for their cooperation and hospitality. The Team Lead concluded the exit briefing. In attendance were:

- (b) (6), (b) (7)(C) Team Lead, Inspections and Compliance Specialist, ICE, OPR, ERAU
- Margaret L. Capel, Auditor, Creative Corrections
- (b) (6), Auditor, Creative Corrections
- (b) (6), (b) (7)(C) OIC, ICE
- (b) (6), (b) (7)(C) PSA Coordinator, SDDO, ICE
- (b) (6), (b) (7)(C) HSA, IHSC
- (b) (6), (b) (7)(C), Project Manager, AhtnaSTS
- (b) (6), (b) (7)(C) COS, AhtnaSTS
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) Quality Control Manager, Compliance Office, AhtnaSTS
- (b) (6), (b) (7)(C) Physical Security Inspector, Compliance Office, AhtnaSTS
- (b) (6), (b) (7)(C) Physical Security Inspector and Quality Control Officer, Ahtna.STS

- (b) (6), (b) (7)(C) Contracting Officer Rep., ICE
- (b) (6), (b) (7)(C) Quality Assurance Officer, AhtnaSTS
- (b) (6), (b) (7)(C) SDDO, ICE
- (b) (6), (b) (7)(C) Quality Control, AhtnaSTS
- (b) (6), (b) (7)(C) Quality Assurance Officer, Compliance, AhtnaSTS
- (b) (6), (b) (7)(C) Physical Security Inspector/Quality Control, Compliance, AhtnaSTS
- (b) (6), (b) (7)(C) Physical Security Inspector/Quality Control, Compliance, AhtnaSTS

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.

Exceeds the Standard (2):
§115.31 - Staff training
§115.32 - Other training

Meets the Standard (31):

§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
§115.17 - Hiring and promotion decisions
§115.18 - Upgrades to facilities and technologies
§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight
§115.33 - Detainee education
§115.34 - Specialized training: Investigations
§115.35 - Specialized training: Medical and mental health care
§115.43 - Protective custody
§115.51 - Detainee reporting
§115.52 - Grievances
§115.54 - Third-party reporting
§115.61 - Staff reporting duties
§115.62 - Protection duties
§115.63 - Report to other confinement facilities
§115.64 - Responder duties
§115.65 - Coordinated response
§115.66 - Protection of detainees from contact with alleged abusers
§115.68 - Post-allegation protective custody
§115.71 - Criminal and administrative investigations
§115.72 - Evidentiary standard for administrative investigations
§115.76 - Disciplinary sanctions for staff
§115.77 - Corrective action for contractors and volunteers
§115.78 - Disciplinary sanctions for detainees
§115.81 - Medical and mental health assessment; history of sexual abuse
§115.82 - Access to emergency medical and mental health services
§115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 - Data collection
§115.201 Scope of audits

Not Applicable: (1)

§115.14 - Juvenile and family detainees

Does not meet (7):

§115.21 - Evidence protocols and forensic medical examinations
§115.41 - Assessment for risk of victimization and abusiveness
§115.42 - Use of assessment information
§115.53 - Detainee access to outside confidential support services
§115.67 - Agency protection against retaliation
§115.73 - Reporting to detainees
§115.86 - Sexual abuse incident reviews

PROVISIONS

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

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

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

Notes:

Documents Reviewed:

PIDC Policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Facility Organizational Chart
Memorandum – Deputy Field Office Director (DFOD) approval of policies

(c): PIDC Policy 4.5.13 states, "It is the policy of the Port Isabel Detention Center (PIDC) to ensure the safety and wellbeing of detainees housed at this facility. It is the responsibility of ICE to protect detainees from sexual abuse, sexual harassment, personal injury and/or abuse. All sexual conduct between detainees, staff, volunteers, or contract personnel, regardless of consensual status, is strictly prohibited and subject to administrative, disciplinary and criminal sanctions. ICE has a standard of zero-tolerance for any form of said sexual activity. The policy outlines the facility's approach to prevent, detect, and respond to such conduct. The approach includes to provide PREA training to staff, contractors and volunteers and PREA education to detainees; to screen detainees for risk of victimization or abusiveness; to investigate all allegations of sexual abuse or assault; to provide medical and mental health care to victims of sexual abuse; and to provide forensic exams to victims of sexual assault." The facility policies were approved by the Field Office Director (FOD) on February 12, 2020.

(d): The facility is an ICE managed processing center, who employs a full time ICE Prevention of Sexual Assault (PSA) Compliance Manager who reports to Facility Administrator. During the interview, the ICE PSA Compliance Manager explained he is responsible for overseeing all PREA allegations, is the facility point of contact for the agency PSA Coordinator and the contractor's PSA Compliane Manager, oversees intake operations, the intelligence unit, and gang operations. He feels he has sufficient time and authority to fulfill his responsibilities as the ICE PSA Compliance Manager.

During the site visit, the Auditors learned the ICE PSA Compliance Manager is now, Gerardo Aquilar. The contract PSA Compliance Manager is now Bruce Carter. The contract PSA Compliance Manager (also the facility investigator) oversees PREA matters for the contractor and reports information to the ICE PSA Compliance Manager. The ICE PSA Compliance Manager's name and contact information is displayed on the ICE Zero Tolerance poster in each of the detainee housing areas. Informal interviews with both PSA Compliance Managers confirm they have adequate time to fulfill their responsibilities in their new role.

The facility meets the requirements of this 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:

Documents Reviewed:

PIDC Policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Organizational Chart
Annual reviews of policies and post orders
Exhibit 2 – Post Orders
Exhibit 3 – Annual 40-hour Refresher Training Syllabus
Exhibit 4 – Documented Unannounced Rounds

(a)(b): Policy PIDC 4.5.13 states, "The facility will maintain sufficient supervision of detainees by providing adequate staffing levels, and where applicable, video monitoring, to protect detainees against sexual abuse. The Officer in Charge (OIC), Assistant Officer in Charge (AOIC), or Assistant Field Office Director (AFOD) will determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated annually." The Auditor's review of the investigation files and incidents reviews found there were no recommendations related to staffing.

The comprehensive supervision guidelines are outlined in the facility's post orders and policies. The facility reviews policies and post orders annually. During the Pre-audit phase, the Auditors reviewed the last review completed January 2020 and was signed by the OIC and Health Services Administrator (HSA). While on-site, the Auditors reviewed the current year's annual review of post orders and policies completed in January 2021.

The Acting Facility Administrator and PSA Compliance Manager stated that the facility maintains adequate staffing levels by maintaining a 60:1 detainee to officer ratio and utilizes video technology. The facility employs 430 security staff. Security staffing is provided through a contract with AhtnaSTS Support and Training Services. The facility requires at least one officer in the detainee housing areas at all times. During the on-site visit phase, the Facility Administrator advised the Auditor that staffing levels have remained the same even though the facility is only allowed to be at 75% capacity due to COVID 19.

(c): Policy PIDC 4.5.13, "States in determining adequate levels of detainee supervision, and determining the need for video monitoring, PIDC will take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting of facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports, the length of time detainees spend in agency custody, and any other relevant factors."

(b) (7)(E) These cameras are monitored from the control center. The video surveillance equipment was installed in 2017 and has not been upgraded since that time. However, while on-site, the Chief of Security indicated only exterior cameras are equipped with pan, zoom, and tilt features. The facility underwent new security upgrades to include a new camera system and new outside lighting. (b) (7)(E) Video footage is stored on a network video recorder (NVR) for six-months. The facility contains one single cell housing unit, 16 multiple occupancy cell housing units, four open dorm housing units, seven segregation cells, 22 medical beds, and six mental health beds.

The Acting Facility Administrator stated the facility maintains compliance with the Performance-Based National Detention Standards (PBNDS) and American Correctional Association (ACA) standards and consideration is given to the physical layout of the facility, investigation findings, the length of time detainees spend in custody, and the composition of the detainee population. She stated there had been no judicial findings of inadequacy. The AhtnaSTS Project Manager stated security officers are posted on the floor in every housing unit.

(d): Policy PIDC 4.5.13 states, "Frequent unannounced security inspections will be conducted to identify and deter sexual abuse of detainees. Inspections will occur on night as well as day shifts. Staff is prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility." Detention officers and supervisors all reported conducting unannounced rounds on an irregular basis. Supervisors report they conduct unannounced rounds to all areas accessible to detainees and log the rounds in the logbook. Detention officers report making unannounced rounds every 15 to 30 minutes and logging these rounds in the logbook. The facility provided an example of documentation of unannounced security rounds by security supervisors and officers. The Auditor asked to review unannounced security rounds for November 1, 2019, January 2, 2020, and May 1, 2020. The facility provided copies of these rounds from the security logbook. The Auditor determined rounds were made on each of these dates, for all three shifts. During the site visit, the Auditors reviewed unannounced security inspections for day and night shifts and found irregular rounds were made consistently on both day and evening hours.

The facility meets the requirements of this standard.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)Not Applicable (provide explanation in notes)

Notes:

Documents Reviewed:

Pre-Audit Questionnaire
Exhibit 5 – Memorandum - Juvenile and Family Unit Detainees
Facility Detainee Roster

(a)(b)(c)(d): The facility provided a memorandum from the AFOD stating that PIDC does not house juveniles or family units. This Auditor also reviewed a facility detainee roster with date of birth information which further verified there are no juvenile detainees housed at the facility.

This standard is not applicable as juveniles are not housed at this facility.

§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:

Documents Reviewed:

PIDC Policy 4.5.13 – Sexual Abuse and Assault Prevention and Intervention
Exhibit 5 – Memorandum - Juvenile and Family Unit Detainees
Exhibit 6 – Memorandum – Cross Gender Viewing and Searches
Exhibit 7 – Search training course outline

(b)(c)(d)(e)(f): PIDC Policy 4.5.13 states, "Pat-down searches of male detainees by female staff will not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Pat-down searches of female detainees by male staff will not be conducted unless in exigent circumstances. All pat-down searches by staff of the opposite gender will be documented. Strip searches or visual body cavity searches by staff of the opposite gender will not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. All strip searches and visual body cavity searches will be documented." All strip and body cavity searches are documented on the Record of Search form. The form documents the reasons for the search and the name and signature of the searching staff and witnesses. The facility provided a memorandum from the SDDO stating there have been no cross-gender pat-searches, no strip searches and no body cavity searches in the past 12 months.

The male security staff interviewed reported they have never conducted a pat-search of a female detainee, or a strip or body cavity search of any gender detainee. Female security staff interviewed reported several years ago, female staff conducted pat-searches of male detainees but that is no longer allowed. One female officer recalled conducting a strip search several years ago of a female detainee that was placed on suicide precautions. She reported medical staff was present. All female staff reported they do not conduct cross-gender pat-searches of male detainees and have not conducted a strip or body cavity search of male or female detainees. During the on-site visit phase, the ICE PSA Compliance Manager advised the Auditors there had been no cross-gender searches conducted since the Remote Interview phase.

Recommendation: The facility or agency should modify the Record of Search form to include the gender of the detainee and the gender of the searching staff and witnesses.

(g): PIDC Policy 4.5.13 states, "Detainees will be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell and hold room checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender will announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing."

The detainees reported they are afforded privacy when performing bodily functions, showering, and changing clothing. Security staff reported there is a half-wall in the shower/toilet area of the male housing areas that affords detainees privacy to shower, change clothing, and perform bodily functions. The facility provides shower curtains in the female housing areas. Staff reported they would announce their presence when entering an opposite gender dorm but that they are not assigned to work in opposite gender housing. All staff reported they would announce their presence before entering and most detainees interviewed confirmed female staff announce their presence when entering the housing area. During the on-site visit phase**,** the Auditors toured all areas of the facility accessible to detainees, except for the cohort housing areas; and observed privacy is afforded to detainees in the housing areas. There was one problem noted with the camera view from the control center of the suicide precaution cell in medical. The Auditors found the toilet area was visible to the control room officer. The Facility corrected this during the on-site visit and Auditors viewed the modified control room camera view and found the blackened area of the toilet area, provides the privacy required.

(h): This section of the standard is not applicable. Juveniles and families are not housed at this facility. The facility provided a memorandum from the AFOD stating the PIDC does not house juveniles or family units. This Auditor also reviewed a facility detainee roster with date of birth information which further verified there are no juvenile detainees housed at the facility.

(i): PIDC Policy 4.5.13 states, "PIDC will not search or physically examine a detainee for the sole purpose of determine (sic) the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner." The security personnel interviewed all reported they have never witnessed, nor would they conduct a search or examination for the purpose of determining a detainee's gender. The Auditor did not interview transgender detainees, there were no transgender detainees assigned to the facility at the time of the Remote Interview phase or during the on-site visit.

(j): The Training Coordinator stated the facility trains security personnel to conduct proper searches in pre-service and annual refresher training. The facility provided a copy of the search training course material. This course provides very clear instructions to security personnel on how to search professionally, respectfully, and in the least intrusive manner possible; required search documentation; gender requirements for searches; instructions for strip and body cavity searches; and searches of transgender detainees. Staff attending training sign a search training certificate after completion of the course. During the Remote interview, security staff were able to describe the procedures in conducting a proper pat search, and detention officers and supervisors confirmed they received annual search training which included, cross gender searches, and transgender or intersex searches. Those interviewed were able to describe how to conduct proper searches in general and specifically for cross gender searches and searches of transgender or intersex detainees.

The facility meets the requirements of this standard.

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

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

Notes:

Documents Reviewed:

PIDC Policy 4.5.13 – Sexual Abuse and Assault Prevention and Intervention
Exhibit 8 – Facility Detainee Handbook
Exhibit 9 – Hotline and ICE PREA posters
Exhibit 10 – ERO Language Line Assistance

(a): PIDC Policy 4.5.13 states, "PIDC will take appropriate steps to ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Such steps will include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, by providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary; providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication."

The Acting Facility Administrator explained that if they receive detainees with disabilities, they are identified at intake by medical staff, but most detainees with disabilities are housed at other facilities. She explained there are posters with pictures (clothing, medical/dental needs, library, etc.), in the housing areas that detainees can use to request common items activities, or needs and a language line is available as well. She reported the facility handbooks are also available in large print and a telecommunications device (TTY) phone is available for deaf detainees. This allows detainees who do not hear well or who may suffer speech impairments to communicate common requests to the housing area officer.

During the remote interview phase, the facility housed only one detainee with a disability. The detainee was unable to read. The detainee reported when he arrived at the facility, the intake staff "went out of their way" to read important information to him about sexual safety. He stated he was told if he had any questions to immediately reach out to staff. The detainee was very knowledgeable about how to report sexual abuse. Most security staff interviewed reported they had never supervised a detainee who was blind, but many said they would read and explain the important material (how to report sexual abuse, zero tolerance for sexual abuse) to the detainee. During remote interviews, some officers reported there may be PREA material available in braille at the facility, while on-site the Auditor verified that there was no braille material at the facility. Intake staff reported the audio portion of the video is available to provide orientation material to blind or visually impaired detainees. Several security officers reported they had worked with detainees who were deaf. They reported there are posters and handbooks that allow the detainee to point to commonly requested items, activities, or programs accessible in each housing area. Intake staff reported the orientation program provides ICE National Detainee handbooks and facility handbooks to detainees who are deaf or hard of hearing and a TTY machine is also available. Security officers provided a range of responses when asked how to assist a detainee who suffered from mental illness, intellectual deficits, or speech impairments. The responses ranged from providing simple explanations, having a friend explain the material, or reading the material to the detainee. Security supervisors reported they would refer the detainee to medical or mental health staff. Intake staff reported they would explain the orientation material to detainees who suffered from mental illness, intellectual disabilities, or speech impediments, and would contact medical if necessary.

During the on-site visit phase**,** the Auditors asked about the available large print handbooks. Although the large print handbooks were not immediately available, staff provided a large print ICE National Detainee Handbook and facility handbook for the Auditor's review before the end of the on-site visit.

The facility has the ability to print the large print handbook as needed. If a detainee is disabled, intake staff read designated pages from the handbook to the detainee through an interpreter.

During the on-site visit phase**,** the Auditors were informed there were no disabled detainees at the facility. Medical staff reviewed with the Auditors the available communication services available through the medical department for disabled detainees to include: a Video Relay Service to assist the deaf or hard of hearing; Eye-Pal Ace Plus (a scan and read device which reads text from a document in English or Spanish to blind or visually impaired individuals); Interpretype (laptop device for visually or hearing impaired such as VRS for communicating with a sign language interpreter or to read the ICE National Detainee Handbook to blind or visually impaired detainees (available in English only)). The Auditors also observed the ICE Communication Board for the Deaf and Hard of Hearing posting.

(b): PIDC Policy 4.5.13 further states, "PIDC will take steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient (LEP), including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Where practicable, provisions for written translation of materials related to sexual abuse or assault will be made for any significant segments of the LEP population. Oral interpretation or assistance will be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate."

The AhtnaSTS Project Manager explained there are reporting posters in the housing areas in several different languages as well as a language interpretation line, and facility and the ICE National Detainee handbooks available in English and Spanish. The Auditor interviewed 3 English speaking detainees and 24 Spanish speaking detainees, during the Remote Interview phase, and 3 LEP detainees during the on-site phase for a total of 30 detainees interviewed. All detainees reported they received ICE National Detainee handbooks in their language or had excerpts read to them through an interpreter, but no detainees reported seeing a PREA related video. The facility utilizes the ERO Language Services for interpreter services. Security staff explained there are handbooks available in both English and Spanish as well as bi-lingual staff and a language interpretation line. ICE National Detainee Handbooks were available in Arabic, Haitian Creole, Simplified Chinese, Spanish, and English. Intake staff were knowledgeable about how to print copies of the handbook in the remaining six languages available. The ICE National Detainee Handbook is available in 11 languages (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). If the ICE National Detainee Handbook is not available in a detainee's language, intake staff read designated pages related to PREA from the handbook to the detainee through an interpreter. The PREA related ICE Zero Tolerance poster, ICE DRIL reporting poster, the OIG Reporting poster, and the ICE Sexual Abuse and Assault Awareness pamphlet are posted in the intake area and all housing areas in English and Spanish.

(c): PIDC Policy 4.5.13 states, "In matters relating to allegations of sexual abuse, the facility will employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. PIDC will provide detainees with disabilities and LEP detainees with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services will be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the facility determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." There were no sexual abuse allegations from detainees with disabilities reported during the audit period.

Of the six investigation files and sexual abuse reports reviewed during the audit, there was no indication of whether an interpreter was utilized, when interviewing non-English speaking detainees.

Recommendation: The Auditor reviewed a total of six sexual abuse reports and investigations and was unable to verify the language of the detainee to include whether an interpreter was utilized in the interview. Investigators should note in the investigative report, the language of the detainee (victim, abuser, witnesses) and whether an interpreter was utilized during the investigative interviews.

The facility meets the requirements of this standard.

§115.17 - Hiring and promotion decisions.

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

Notes:

Documents Reviewed:

5 CFR 731, Part 71 –Suitability
E.O. 10450 – Security Requirements for Government Employment
ICE Directive 6-7.0 Ice Personnel Security and Suitability Program
ICE Directive 6.8.0 ICE Suitability Screening Requirements for Contractor Personnel

(a)(b)(e): The Federal Statute 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, requires anyone entering or remaining in government service, employee or contractor undergo a thorough background examination for suitability and retention. The factors include misconduct or negligence in employment; criminal or dishonest conduct; material, intentional false statement, or deception or fraud; alcohol abuse, illegal use of narcotics, drugs, or other controlled substances. Executive Order 6-7.0 establishes that a criminal background check will be completed for new employees, contractors, and volunteers who have contact with detainees. The Division Chief of the OPR Personnel Security Unit (PSU) informed Auditors who attended training in Arlington, Virginia in September 2018, 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. Applicants must complete a form titled Department of Homeland Security 6 Code of Federal Regulations Part 115. This form asks have you ever engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution as defined in 42 USC 19971; have you ever been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion; have you ever been convicted of engaging or attempting to engage in sexual activity where the victim did not consent or was unable to consent or refuse; and have you ever had a civil or administrative adjudication against you for engaging in activity described in questions 1 through 3

above. This form must also be completed every five years when the criminal background check is completed and if an employee is promoted. If the employee has misrepresented or omitted any facts on this application, and are subsequently hired, they may be discharged from their job. The HR Manager explained employees sign the "PREA form" upon hire, a position change, and every five years when criminal background checks are completed on employees and contractors. The form also includes a continuing affirmative duty to disclose any sexual misconduct described in the previous paragraph. The Auditor reviewed eight files which included employee and contractor files and the PREA form was not available in the files during the Pre-audit documentation review. During the on-site visit phase**,** the Auditors reviewed the same eight employee files which included the "PREA form" which includes the continuing duty to report requirement.

(c)(d): Federal Statute 731.105 requires "background reinvestigations to be conducted on all staff and contractors, having detainee contact with detainees, every five years." The Division Chief of the OPR PSU confirmed that ICE conducts these background checks on contractors and staff. PIDC exceeds the requirement of the five-year updated background check as a background check is conducted through the National Crime Information Center (NCIC) on PIDC staff, contractors, and volunteers annually by the HR Personnel Investigator. The agency conducts background checks to include criminal background checks for all new employees and contractors and every five years thereafter. The Auditor confirmed, through the ICE Personnel Security Unit, that background checks, including criminal background checks, were completed for three OPR investigators, one contract facility investigator, six contract employees and one IHSC staff. The Human Resource Manager for AhtnaSTS explained that they do not hire anyone with a conviction for sexual offenses. She explained the agency completes investigations for all applicants to include a criminal background check and a check with previous employers. The Auditor reviewed the AhtnaSTS employment application. The application informs the applicant that their personal and employment references may be checked.

During the on-site visit phase**,** the Auditors reviewed files for eight employees whose employee files were not provided to the Auditors during the Pre-audit documentation review phase. The review found initial background checks were not available for six of the eight employees because they were hired under the former contractor and the employee files were not available from the previous employer. Two of the employees were hired by the new contractor and both had an initial background on file. Based on information obtained from PSU, all eight employees had current background checks. Five-year background checks were reviewed for each of these employees except for two whose were not due yet.

(f): The interview with the HR Manager confirmed that she would provide information regarding a substantiated allegation of sexual abuse of a former employee to an institutional employer, for whom the employee has applied to work. It was also stated the facility did not report any incidents in which this information was requested.

The facility meets the requirements of this standard.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

Documents Reviewed:

Exhibit 11 – Memorandum – No facility upgrades or expansions

(a): During the pre-audit phase, the facility initially provided a memorandum from the DFOD stating the facility has not designed, modified, acquired, or expanded upon new or existing space, or installed electronic monitoring systems; however, during the on-site visit, the facility staff advised the Auditors that the food service building was being replaced and was scheduled for occupancy in August 2021. (b) (7)(E) [redacted]

(b): The Acting Facility Administrator stated when installing or updating video equipment the facility considers how such technology may enhance their ability to protect detainees from sexual abuse. While on-site, the Chief of Security indicated only exterior cameras are equipped with pan, zoom, and tilt features. The facility underwent new security upgrades to include a new camera system and new outside lighting. (b) (7)(E) [redacted]

The facility meets the requirements of this standard.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
IHSC 03-01 Sexual Abuse and Assault Prevention and Intervention
Exhibit 12 - Memorandum - Detainee Access to Outside Confidential Support Services
Exhibit 13 and 14 - Memorandum of Understanding with the Cameron County Sheriff's Office (CCSO)

(a)(e): The facility evidence protocol is outlined in PIDC Policy 4.5.13 which states, "Investigations regarding allegations of sexual abuse will be initiated by any staff member. Upon identifying that a sexual assault or threat has occurred, the alleged victim will be immediately relocated to a safe and secure location. It is imperative that the alleged victim be separated from the alleged perpetrator. Staff members will attempt to identify the alleged perpetrator(s) and segregate pending a full investigation. Any allegation of sexual abuse will be immediately reported through the PIDC chain of command, as well as a method by which staff can report outside the chain of command. All affected areas will be on lockdown pending interviews of all persons at or near the area of the alleged act."

According to the PAQ and the interview with the PSA Compliance Manager, the CCSO and OPR conduct investigations at the facility. Both agencies have the authority to conduct criminal investigations. The facility provided a copy of the Memorandum of Understanding (MOU) between PIDC and the CCSO. There was one allegation referred to the sheriff's office for investigation, but the alleged victim declined to pursue criminal charges.

Agency policy 11062.2 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 incident review personnel in accordance with OPR policies and procedures. OPR

does not perform sex 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 Field Officer 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 OIG, OPR, or local law enforcement agency, the AFOD would assign an administrative investigation to be conductedOnce an allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. The ICE/OPR Investigator explained that although ICE/OPR Investigators can conduct criminal investigations, if the incident appears to be criminal in nature, the investigation is referred to the CCSO who conducts criminal investigations for the facility. The Auditor reviewed a total of five investigative summaries conducted by OPR, and one completed by the contract Investigator. One allegation was substantiated, two allegations were unsubstantiated, and two were unfounded; The remaining investigation (administrative investigation) which was reviewed while on-site, was closed at the facility level based on the facility investigator's detemination that it was not PREA related, and it was not reported to the JIC. Based on the Auditor's review of the "Sexual Abuse/Assault Definitions and Determination Worksheet" the investigator had marked yes to one of the questions on the worksheet; based on the instructions on the form, any yes answer must be reported to ICE Management immediately. Based on an interview with the facility investigator and the ICE PREA Manager, the allegation was not reported to the JIC because they determined it was "horseplay" and not PREA.

(b): PIDC policy 4.5.13 states "PIDC is in agreement with community service providers that offer legal advocacy and confidential emotional support services for immigrant victims of crime." PIDC has an informal agreement with three community providers: Women Together/Mujeres Unidos, Family Crisis Center, Inc., and Friendship of Women, Inc. to provide legal advocacy and confidential emotional support services for immigrant victims of crime. The Auditor was able to contact representatives from Women Together/Mujeres Unidas and the Family Crisis Center, Inc., who reported they do provide services to detainee victims at the facility. Women Together/Mujeres Unidas reported they provide counseling, crisis intervention, and advocacy services during the investigation and prosecution of allegations. The Family Crisis Center, Inc. reported they provide counseling and crisis intervention services, and that prior to the current pandemic, they would go to the facility, or the facility would transport detainees to them for services. The third organization, Friendship of Women, Inc. did not respond to phone messages.

(c): PIDC Policy 4.5.13 also states, "Where possible and feasible, a victim of sexual abuse, assault, or any mistreatment will be referred under appropriate security provisions to a specialized community facility for treatment and gathering of evidence. Gathering of clinical forensic evidence will be conducted by external, independent, and qualified health care personnel." The HSA explained when applicable and with the victim's consent, forensic examinations are provided through Valley Baptist Medical Center (VBMC) at no cost to the detainee victim. The Auditor spoke with nursing staff in the emergency room of VBMC and they confirmed they provide a SAFE/SANE certified examiner to complete forensic examinations of detainee victims of sexual assault. The facility is working with the VBMC to develop an MOU regarding these services. None of the allegations required the detainee to obtain a forensic exam.

(e): The Auditor reviewed an MOU between the facility and the CCSO, provided by the facility. The MOU was primarily focused on providing emergency assistance in the event of an institutional emergency such as a bomb threat, escape, and staff work stoppage. The MOU does not address any PREA related services or assistance. The Auditor found the current MOU addresses institutional emergencies, i.e., escape, weather related emergencies and the like, but does not address PREA investigations or PREA related services provided by the CCSO. The PSA Compliance Manager stated he will work with the CCSO to modify the MOU to include PREA investigations conducted by the CCSO. During the on-site phase, the Auditor explained that the standard requires the facility to request the CSSO follow the requirements of paragraphs (a) through (d) but does not require a formal MOU.

Does Not Meet (e): The facility has not requested CSSO to follow the requirements of paragraphs (a) through (d) of this standard. The facility must request and provide verification that the facility has requested the CCSO to follow the requirements of sections (a)-(d) of this standard.

The facility does not meet the requirements of this standard.

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

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

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 13 and 14 – MOU with CCSO
Exhibit 15 – Memorandum – Policies to Ensure Investigation of Allegations and Appropriate Agency Oversight

(a)(b)(d): PIDC Policy 4.5.13 states, "All allegations of sexual abuse or assault will be immediately and effectively reported and investigated. Detainees will not be punished for truthfully reporting sexual abuse/assault or signs of abuse/assault observed." This policy outlines the duties of the Administrative Investigator as well as the role of the facility when outside agencies conduct the sexual abuse investigation.

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

PIDC policy 4.5.13 instructs staff to lockdown all affected areas, which will remain pending interviews of all persons at or near the area of the alleged act. The contract facility investigator interviews the alleged victim, alleged abuser, and any witnesses and reviews any available video footage and prior complaints by the alleged abuser and makes a credibility assessment of the victim, abuser and witnesses. The contract facility investigator makes a determination if staff actions or failure to act contributed to the abuse. A report is written and maintained for five years. When outside agencies investigate sexual abuse and assault, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation.

The ICE OPR investigator interviewed by the Auditor reiterated the process outlined above; he added that at times, local law enforcement and the agency decline to investigate an incident and it is referred to the PSA Compliance Manager for an administrative investigation to be completed. When the agency completes the investigation, the facility is notified that the investigation is closed and of the findings (substantiated, unsubstantiated, or unfounded). The facility does not receive a copy of the completed OPR investigations.

During the remote interview phase,the Auditor received conflicting information from agency, facility, and contract staff regarding who completes administrative investigations. During the on-site visit phase**,** the Auditors interviewed several staff informally to include the contract PREA Investigator/contract PSA Compliance Manager, contract Compliance Officer, AhtnaSTS Project Manager, and the ICE PSA Compliance Manager, who all confirmed that administrative investigations are now completed for all PREA allegations by the contract facility investigator. The Auditors discussed the investigation process in depth with the PSA Compliance Manager and contract Investigator/contract PSA Compliance Manager. These investigations are conducted by the contract facility investigator and forwarded to all affected parties. All parties are provided copies of the administrative investigations and these reports are provided to Sexual Abuse Incident Review boards for review.

Of the six PREA investigations, all were allegations of detainee-on-detainee abuse; four were unsubstantiated, one was substantiated and one was deemed not to be PREA related. One case was referred to the CCSO, but the CCSO declined to investigate the case and the investigation was completed by OPR. In review of the five investigative files, the facility made all of the proper notifications to JIC and the facility administration, except for the one deemed not to be PREA related by the facility.

(c): The facility provided a memorandum stating the facility does not have their own website but the protocols for investigating allegations of sexual abuse are posted on the agency website at: www.ice.gov/prea. This was confirmed by the Auditor.

(e)(f): The Acting Officer in Charge (AOIC) confirmed that all notifications are made when a PREA allegation is received. She explained staff have a PREA checklist that is initiated when an allegation is received. This checklist ensures staff follow the facility protocols, make the proper notifications in accordance with policy and the standards requirement, separate the victim and abuser, ensure evidence is preserved, and the alleged victim is seen by medical staff.

There was one PREA allegation reported by the facility but it was not reported to JIC. The contract facility investigator explained he did not report the allegation to the JIC because he conducted an administrative investigation and determined the incident was horseplay, the allegation was unsubstantiated and deemed an unrelated PREA incident. The investigation report included a completed ICE Sexual Abuse/Assault Definitions and Determination Worksheet. The form directs that if any affirmative responses to items on the worksheet are received, the allegation must be reported to ICE Management immediately. The incident was reported to the ICE PSA Compliance Manager. He was informed by the contract PSA Manager/Investigator the incident was not PREA-related so the allegation was not reported to JIC. However, the facility is found compliant based on substantial compliance found in five of the six investigation files reviewed.

The facility meets the requirements of this standard.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)Choose an item.

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 17 – PREA Training (Initial and Refresher) Curriculum

(a)(b): PIDC Policy 4.5.13 states, "PIDC's SAAPI Program will be included in training for employees, volunteers, and contract personnel and will also be included in annual refresher training thereafter. Training will include the facility's zero-tolerance policy for all forms of sexual abuse or assault; definitions and examples of prohibited and illegal behavior; the right of detainees and staff to be free from sexual abuse and agency prohibitions of retaliation against detainees and staff who report sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral, and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee-victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition, and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; instruction on reporting knowledge or suspicion of sexual abuse and/or assault and making intervention referrals to the facility's program; instruction of documentation and referral procedures of all allegations or suspicion of sexual assault and/or assault and making intervention referrals to the facility's program; and how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex (LGBTI), or gender nonconforming detainees."

The Auditor reviewed the PREA training curriculum and found it addresses each topic required by this standard. The Training Supervisor confirmed this training is provided to all new facility staff, contract staff, and volunteers, as well as to all staff annually in refresher training. He explained the training includes lectures, PowerPoint slides, and exercises. He added the training is specific to the participant's position at the facility. The standard requires refresher training every two years. All staff interviewed confirmed receiving the initial PREA training and refresher training annually which exceeds the requirements of the standard.

(c): PIDC policy 4.5.13 states, "The facility will maintain written documentation verifying employee, volunteer and contractor training." The Auditor reviewed ten training files for facility staff and found that each was provided PREA refresher training annually; however, the initial PREA training was missing from several files. The PSA Compliance Manager explained those documents were kept by the previous company and not accessible by the facility. The training attendance records and supporting documentation are maintained in the training files.

The facility exceeds the requirements of this standards.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documents Reviewed:

PIDC Policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 18 – PREA Training Curriculum for Volunteers

(a)(b)(c): PIDC Policy 4.5.13 states, "All volunteers and other contractors who have contact with detainees will be trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention, and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have contact with detainees will be notified of the PIDC's zero tolerance policy and informed how to report such incidents."

The Auditor reviewed the training curriculum for volunteers and contract staff. The Training Supervisor confirmed that all volunteers and contract staff receive initial PREA training provided by facility trainers. This was also confirmed through interviews with volunteers and contract staff. The Training Supervisor confirmed the training provided to contract staff and volunteers is based on the services they provide and level of contact with detainees.

(c): PIDC policy 4.5.13 states, "The facility will maintain written documentation verifying employee, volunteer and contractor training." Training documentation is maintained for each contract staff and volunteer. The Auditor reviewed training records for three contract staff and two volunteers and verified the initial and annual PREA training.

The facility exceeds the requirements of this standard.

§115.33 - Detainee education.

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

Notes:

Documents Reviewed:

PIDC Policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 8 – Detainee Handbook
Exhibit 9 – PREA Posters and Pamphlets
Exhibit 19 – Detainee Education
Exhibit 20 – Documentation of detainee orientation and property sheet
Exhibit 21 – DHS-prescribed Sexual Assault Awareness Information pamphlet
Exhibit 22 – ICE National Detainee Handbook

(a): PIDC Policy 4.5.13 states, "The OIC, AOIC, or AFOD will ensure that the orientation program required by the detention standard on Admission and Release, and the detainee handbook required by the detention standard on detainee handbook, notify and inform detainees about the PIDC's zero-tolerance policy for all forms of sexual abuse and assault. Following the intake process, detainees are provided instruction on PIDC's Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program, instruction includes (at a minimum): PIDC's zero-tolerance policy for all forms of sexual abuse or assault; the name of the SAAPI Program Coordinator and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the ICE/ Detention Reporting and Information Line (DRIL), the DHS/OIG and the ICE/OPR investigation processes or their consular official; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting an assault will not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse or assault to receive treatment and counseling. The above-mentioned detainee instruction will be documented, and such documentation will be maintained according to a prescribed schedule."

Intake staff stated detainees are provided with the facility's and the ICE National Detainee Handbook, which provides information about the PREA DHS-prescribed Sexual Assault Awareness Information pamphlet, PREA orientation video, group instruction, and individual instruction as needed. The detainees interviewed reported they received at least one handbook but denied seeing a PREA video while in intake; however, several detainees commented that a video that discusses PREA is frequently played in the housing areas. While on-site, the Auditors asked to review the documentation of the PREA educational information provided at intake. The facility provided a copy of a blank Detainee Personal Property Sheet, in which intake staff document if the detainee received the handbook, watched the PREA orientation video, and were verbally oriented. . The form did not specify if the handbook was the ICE Detainee handbook or facility handbook. The Auditor interviewed 30 detainees, 26 being LEP detainees. The detainees reported receiving a handbook (unspecified) and verbal orientation. Detainees were asked if this information informed them about how to stay safe, warning signs, reporting options, right to medical treatment and emotional support, and that they would not be punished for reporting. All detainees reported receiving this information.

Recommendation: The facility should consider updating the Detainee personal Property Sheet (form for documenting detainee education, etc,) to specify receipt of both the ICE National Detainee handbook and the facility handbook separately. The facility should specify the language of the handbooks provided, and if an interpreter was utilized to conduct the interview and/or provide PREA information.

(b)(c): PIDC Policy 4.5.13 states, "PIDC will provide the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are LEP, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The above-mentioned detainee instruction will be documented, and such documentation will be maintained according to a prescribed schedule." The Auditor interviewed a total of 30 detainees, 26 of whom were LEP detainees. The detainees reported receiving a handbook (unspecified) and verbal orientation. Detainees were asked if this information informed them about how to stay safe, warning signs, reporting options, right to medical treatment and emotional support, and that they would not be punished for reporting. All detainees reported receiving this information. The Auditors reviewed 11 detainee files. The Property Sheet form provides an area for entering whether the detainee received handbooks and watched a video. The Auditor was able to verify nine detainees received the ICE Detainee Handbook or information was provided through an interpreter and received PREA orientation but did not include the language of the handbooks provided.

During the Remote Interview phase, the facility informed the Auditors there was no detainees with disabilities. However, during the detainees' interviews, the Auditor interviewed a detainee who was unable to read. The detainee explained that intake staff "went out of their way" to read all pertinent sexual safety information to him. Staff informed him if he had any questions, he could contact staff for assistance. The detainee was very knowledgeable about how to report sexual abuse. During the on-site visit, there were no disabled detainees at the facility for interviews per the facility. The only detainees who were LEP spoke Spanish. Each detainee reported they received the ICE National Detainee and facility handbooks in a language they could understand. The facility handbook was reviewed by the Auditor.

The facility handbook is available in English and Spanish and provides information for detainees with disabilities about available accommodations and LEP detainees about language and communication assistance. The ICE National Detainee Handbook is available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). The facility has the ICE National Detainee Handbooks available in Arabic, Haitian Creole, Simplified Chinese, Spanish, and English. Intake staff were knowledgeable about how to print copies of the remaining six languages available. Both handbooks provide information, to detainees, about how to report sexual abuse and their rights to be free from sexual abuse. If the ICE National Detainee Handbook is not available in a detainee's language or the detainee is disabled, intake staff read designated pages from the handbook to the detainee through an interpreter.

The Auditors interviewed 4 English speaking detainees and 26 Spanish speaking detainees. All detainees reported they received ICE National Detainee handbooks in their language but reported they did not see a PREA video. The second Auditor observed intake for one detainee, which included observing that the PREA video was being played on the televisions in all of the holding cells. The video was not observed by the Auditors being played while in the housing units. All detainees reported receiving PREA orientation from staff or through an interpreter. The facility utilizes the ERO Language Services for interpreter services. Security staff explained there are handbooks available in both English and Spanish as well as bi-lingual staff and a language interpretation line. During the facility tour, the PREA related ICE Zero-Tolerance poster, ICE DRIL reporting poster, the OIG Reporting poster, and the ICE Sexual Abuse and Assault Awareness pamphlet are posted in the intake area and all housing areas in English and Spanish. The ICE Sexual Abuse and Assault Awareness pamphlet is available in nine languages, English, Spanish, Arabic, Chinese, French, Haitian Creole, Hindi, Portuguese, and Punjabi, and available for printing by the facility if needed.

(d) The facility has posted in all the housing areas the DHS-prescribed Sexual Assault Awareness notice, ICE Zero-Tolerance poster, Safe Hotline poster, and the Sexual Abuse and Assault Prevention and Intervention Program Coordinator poster with the name of the PSA Compliance Manager. All the postings are available in English and Spanish. The ICE Zero Tolerance poster includes the name and contact information for the PSA Compliance Manager and reporting information in eight languages (English, Arabic, Simplified Chinese, French, Haitian Creole, Portuguese, Vietnamese, and Spanish); and a poster titled Safe Hotline – Sexual Assault Victim Service Providers which provides the names, addresses, and phone numbers for three local community victim service providers. During the on-site visit, the Auditors confirmed these posters are posted in all detainee housing areas, medical, intake, sallyport, and throughout the facility.

(e): The DHS-prescribed Sexual Assault Awareness Information pamphlet is available in English and Spanish and provides information to detainees about how to report sexual abuse. The detainees interviewed reported they did not receive a copy of the DHS-prescribed Sexual Assault Awareness Information pamphlet, but that these pamphlets are posted in the detainee housing areas. However, during the on-site visit phase**,** the Auditors confirmed the DHS-prescribed Sexual Assault Awareness Information pamphlet is provided to detainees at intake.

(f): The Auditor reviewed the ICE National Detainee Handbook and the local detainee handbook and found each provided information about reporting sexual abuse and detainees' rights to be free from sexual abuse. The facility's handbook directs the detainee they can report a sexual assault incident to facility staff, ICE ERO personnel, or DHS or ICE headquarters, including tell any staff member at the facility you trust (for example, the Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program Coordinator, medical staff, chaplains, housing unit officers, supervisors, etc.); file an informal or formal grievance (including emergency grievance) with the facility; sick call requests; or contact the SAAPI Program Coordinator at 411# using any of the detainee telephones; tell an ICE ERO staff member who visits the facility; file a written informal or formal request or grievance to ICE ERO, contact the ICE DRIL, contact the DHS OIG, call the toll-free hotline, and email: www.oig.dhs.gov.

The facility meets the requirements of this 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:

Documents Reviewed:

PIDC Policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 23 – Memorandum OPR and Local Law Enforcement Investigators
ICE Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention

(a)(b): PIDC Policy 4.5.13 states, "In addition to the general training, all facility staff responsible for conducting sexual abuse or assault investigations will receive specialized training that covers, at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The facility will maintain written documentation verifying specialized training provided to investigators pursuant to this requirement."

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

The Auditor reviewed the AhtnaSTS Investigators' training certificate from National Institute of Corrections (NIC) for completion of the course titled PREA: Investigating Sexual Abuse in a Confinement Setting. The Auditor also confirmed the investigator training for the two ICE investigators who handled the investigative cases summaries the Auditor reviewed. The ICE investigator training covers cross-agency coordination in depth. The NIC training covers coordination of efforts between different parties to include other agencies but not to the extent of the agency training. The training meets the requirement of this standard.

The OPR and facility investigators interviewed were experienced and well-trained investigators with an excellent working knowledge of conducting PREA sexual abuse investigations. During the document review phase, the Auditor noted that the security captains are conducting PREA investigative activities, i.e., interviewing staff, and detainees, gathering statements, monitoring recorded videos, and determining whether the alleged incident is, in fact, a PREA related matter; however, the captains have not received the specialized fact finder training. During the on-site visit phase, the Auditors reviewed documentation of training provided to seven supervisors: the AhtnaSTS Supervisor's training: Incident Investigation 101; the AhtnaSTS Training: Incident Investigation 101 training program material; and NIC certificates of completion for the training program entitled PREA: Your Role in Responding to Sexual Abuse. The Auditors determined this training provides sufficient training for staff who serve in the role of fact finders.

In total, the Auditors reviewed six investigations. The five investigations reviewed during the Pre-audit phase were completed by OPR. The one PREA investigation report reviewed on-site, was completed by the facility investigator. All investigators were trained to conduct sexual assault investigations.

The facility meets the requirements of this 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:

Documents Reviewed:

IHSC Directive 03-01 - Sexual or Physical Assault, Abuse and/or Neglect
Exhibit 24 – Healthcare Staff Training Certificates

(a)(b)(c): IHSC Directive 03-01 states, "All IHSC staff receive training on the Sexual Abuse and Assault Prevention and Intervention (SAAPI) directive, PREA standards, and response protocol during initial orientation and annually thereafter throughout their employment with IHSC. The HSA/AHSA, local training coordinator, or other designated IHSC staff member will document all required training. Training will include definition and examples of prohibited and illegal sexual behavior; recognizing situations where sexual abuse may occur; detection and treatment of physically or sexually abused and assaulted detainee victims in ICE custody; appropriate interventions when an incident occurs; description of how to respond effectively and professionally to detainee victims of sexual abuse and assault; recognizing physical, behavioral, and emotional signs of sexual abuse; discussion of how to communicate effectively and professionally to LGBTI or gender nonconforming detainee victims; actions that will assist detainee victims to safeguard physical evidence of sexual abuse and assault; steps for reporting allegations or suspicions of sexual abuse and assault; IHSC staff will not suffer retaliation for reporting abuse or assaults; and how to identify and protect physical evidence with detainee victims, including lesbians and gays, and how to protect physical evidence."

The facility healthcare staff do not conduct forensic examinations. The Training Coordinator reported he provides the general PREA training to medical staff as part of new employee orientation and annual training for all employees, and the medical department provides the specialized training to healthcare staff. During interview, medical staff confirmed they receive specialized PREA training during their quarterly training programs, and the Auditor also confirmed this through a review of training certificates.

The facility meets the requirements of this standard.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 25 – Medical Risk Assessment
Exhibit 26 – Detainee Reassessment

(a)(b): PIDC Policy 4.5.13 states, "Detainees will be screened upon arrival at the facility for potential vulnerabilities to sexually aggressive behavior or tendencies to act out with sexually aggressive behavior and will be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new arrival will be kept separate from the general population until he or she is classified and may be housed accordingly. The initial classification process and initial housing assignment will be completed within 12 hours of admission to the facility." During the audit period, the Auditor interviewed 30 detainees, the majority of these detainees reported they were asked personal questions while in intake.

The Intake staff explained incoming detainees are placed in holding cells in the staging area while they are being processed into the facility, and oriented with the facility's rules and PREA. Intake staff is responsible for processing detainees into the facility. An initial custody assessment is completed during this time, after a thorough review of all available information received through the agency data base. This information may include criminal history, previous incarcerations, institutional adjustment problems, and other pertinent risk assessment information. From this information, a custody score is obtained which determines the detainee's housing assignment, but this can be adjusted dependent upon medical staff recommendations after completing the medical risk assessment. Medical staff conduct an initial evaluation which includes some PREA related questions related to risk of sexual abuse: have you been a victim of sexual abuse; are you in danger of being physically or sexually assaulted; have you received help for a developmental or learning disability; and are you transgender. Based on interviews with intake staff, the information obtained from the intake screening and the detainee's prior history review, the intake staff complete an ICE Detainee Classification System – Primary Assessment form for all incoming detainees to determine the detainee's custody score. This score largely determines a detainee's housing placement, separating those detainees with higher custody scores from those with lower scores. This score can be determined from a review of the records, prior to the detainee arriving at the facility. The Classification Supervisor stated the housing placement of detainees can be changed depending on recommendations from the medical or mental health department after completion of the medical risk assessment.

The medical risk assessment or intake documentation does not reflect the time of completion to demonstrate the assessments were completed within 12 hours. Nine of the 30 detainees interviewed reported being in intake only a couple of hours.

The Auditors reviewed 11 detainee files. Three of the detainees did not have risk assessments completed. Of the remaining eight files, all files included the custody assessment, and each were seen by medical and asked some additional questions related to the detainee's risk of victimization.

Does Not Meet (b): The medical risk assessment or intake documentation does not reflect the time of completion to demonstrate the assessments were completed within 12 hours. The initial classification process and initial housing assignments should be completed within 12 hours of admission to the facility. The facility must develop a process to ensure that the initial classification process and initial housing assignments will be completed within 12 hours of admission and can be verified for auditing purposes. The facility must provide training to staff on the revised process. The facility must provide completed assessments for 10 detainees conducted after the on-site visit to demonstrate the assessments were completed within 12 hours of arrival.

(c)(d): PIDC Policy 4.5.13 states, "The facility will consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. The PIDC Policy 4.5.13 also states, "The initial screening will consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to PIDC, in assessing detainees for risk of being sexually abusive. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at PIDC, the facility will consult with the FOD for additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment will not ordinarily exceed a period of thirty (30) days."

The Auditor reviewed 11 detainee files. Seven of these files either did not have a risk assessment or the risk assessment was not completed on the date of admission. Some risk factors are gathered as part of the custody assessment and entered on the ICE Detainee Classification System – Primary Assessment form. These risk factors include whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child. The completion of these two assessments completes the current PREA risk assessment for the detainee. The current risk assessment process does not ask if the detainee identifies as gay, lesbian, bisexual or is gender non-conforming; does not consider the detainee's build and appearance as a risk factor; age is noted but it is not considered as part of the risk assessment. The facility reports medical staff advises classification if, in their opinion, the detainee is at risk of sexual victimization. The risk assessment process does not consider all risk factors in total to determine if the detainee is at risk of victimization or abusiveness. The sharing of this information is imperative to making an individualized assessment of detainees risk of abusiveness or victimization. Intake staff interviewed explained that ICE provides information to the facility, as it is known to ICE, regarding a detainee's criminal history, prior institutional violence, or sexual abuse.

Does Not Meet (c)(d): The current procedures for assessing a detainee's risk of victimization or abusiveness does not address each of the requirements of the standard. Some questions are asked by intake staff and some questions asked by medical staff. This information is not routinely shared. The facility should revise the risk assessment to ensure all required criteria for risk of victimization are addressed and the determination for risk of victimization is shared with effected parties. The facility must develop a process to capture all the required information to meet the standard requirements in order to assess detainees on intake to identify those likely to sexual aggressors or sexual abuse victims. All required information must be considered during this risk assessment. The facility must provide the process developed to capture all the required information and how the information will be utilized to complete the initial classification and housing assignment as well as documented staff training on the process for compliance review. The facility also must provide 10 examples conducted after the on-site visit to the Auditor to demonstrate compliance.

(e) PIDC Policy 4.5.13 states, "PIDC will reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information, or following an incident of abuse or victimization." The Auditors reviewed 11 detainee files and found reassessments were completed for only four of the detainees. The reassessment form provided was a custody reassessment but did not assess the detainee's risk of abusiveness or victimization. These factors are considered on the medical risk assessment which was not provided. Furthermore, per the Performance-Based National Detention Standards 2011, which PIDC is obligated to comply with, reassessments of the victim and abuser after an incident of sexual abuse are required to be completed within 24 hours; however, they were not completed within the required timeframe.

Does Not Meet (e): A reassessment of a detainee's risk of victimization and abusiveness must be completed within 60-90 days of admission. A reassessment of the victim and abuser must also be completed within 24 hours of the allegation per PBNDS 2011. If the investigation determines the allegations were unfounded, another reassessment may be warranted for the victim and/or abuser, due to receiving additional information based on the results of the investigation. The facility must provide 10 examples conducted after the on-site visit of detainee's risk of victimization and abusiveness being re-assessed within 60-90 days of admission. Additionally, if there is an incident of risk or victimization during the CAP period, the facility must provide reassessments completed for those detainees within the required timeframe.

(f) PIDC Policy 04.05.13 states, "Detainees will not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to items (1), (7), (8), or (9) above (whether the detainee has a mental, physical, or developmental disability; whether the detainee has self-identified as LGBTI or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety)." The PSA Compliance Manager and intake staff confirmed that detainees are not disciplined for refusing to answer the above questions.

(g) PIDC Policy 04.05.13 states, "The facility will implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees." The PSA Compliance Manager explained that sensitive information from the risk assessment is restricted to medical and intake personnel. Access to information in the detainee file and medical file have restricted access and information stored in the facility's database is also restricted.

The facility does not meet the requirements of this standard.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

PIDC Policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 27 – Memorandum – Transgender Detainee files available upon request

(a): As noted in 115.41 above, intake staff explained that ICE provides information to the facility, as it is known to ICE, regarding a detainee's criminal history, prior institutional violence, or sexual abuse. The intake staff complete a Detainee Classification System – Primary Assessment form to determine the detainee's custody score. This score largely determines a detainee's housing placement, separating those detainees with higher custody scores from those with lower scores. This score is determined from a review of the records, prior to the detainee arriving at the facility. The Classification Supervisor and intake staff stated the housing placement of detainees can be changed depending on recommendations from the medical or mental health department after completion of the medical risk assessment. The facility makes housing placements, recreation, other activities, and voluntary work based on the custody scores and medical recommendations, if any. During the on-site visit, the Auditors reviewed the facility's process for gathering information about a detainee's PREA risk factors when making initial housing assignments. Although medical and/or mental health staff advise classification staff if they determine a detainee is at risk of victimization, all risk factors are not taken into consideration when making housing and program placement decisions.

Does Not Meet (a): The facility does not have a formal risk assessment process and does not consider all required risk factors when making housing and program assignments. The current risk assessment process does not ask if the detainee identifies as gay, lesbian, bisexual or is gender non-conforming; the detainees build and appearance; age is noted as a risk factor on the intake risk assessment or medical risk assessment but is not considered as part of the risk assessment. The facility reports medical staff advises classification if, in their opinion, the detainee is at risk of sexual victimization. The risk assessment process does not consider all risk factors in total to determine if the detainee is at risk of victimization or abusiveness. The sharing of this information is imperative to making an individualized assessment of detainees' risk of abusiveness or victimization. The facility must develop a process to capture all the required information to meet the standard requirements in order to assess detainees on intake to identify those likely to sexual aggressors or sexual abuse victims. All required information must be considered during this risk assessment. The facility must provide the process developed to capture all the required information and how the information will be utilized to complete the initial classification and housing assignment as well as documented staff training on the process for compliance review, as recreation and other programs are largely determined by the detainee's classification and housing assignment. The facility also must provide ten examples over a time period established by the Auditor to demonstrate compliance.

(b): PIDC Policy 4.5.13 states, "When making assessment and housing decisions for a transgender or intersex detainee, 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. The facility will consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender, and self-assessment of safety needs will always be taken into consideration as well. The facility's placement of a transgender or intersex detainee will be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee will be reassessed at least twice each year to review any threats to safety experienced by the detainee."

The medical staff interviewed confirmed that the medical and mental health staff are consulted prior to making housing placement decisions for transgender detainees. The Auditor reviewed one transgender detainee file and medical record. The detainee was seen by medical upon admission, identified as transgender, and the detainee was placed in the Mental Health Unit (MHU) where she was seen by mental health staff as well. The detainee remained in MHU for safety reasons. There was no documentation of a reassessment of this detainee because the detainee was released from custody 41 days later and a reassessment was not due.

During the on-site visit, the Auditor reviewed an investigation file in which the detainee stated she was transgender (for the first time) when making an allegation of sexual abuse to mental health staff. The detainee was asked if she felt safe returning to her current housing assignment or assignment to the MHU. The detainee chose to remain in the assigned housing area. The detainee was released within days of making the sexual abuse allegation.

(c) PIDC Policy 4.5.13 states, "When operationally feasible, transgender and intersex detainees will be given the opportunity to shower separately from other detainees." The Classification Supervisor explained that transgender detainees are afforded the opportunity to shower separately from other detainees. There are showers available in the medical area for this purpose. Security staff reported individual showers are provided in the medical area, mental health unit, or intake area. While on-site, facility staff interviewed stated transgender detainees can shower separately in their housing units, medical, or intake.

The facility does not meet the requirements of this standard.

§115.43 - Protective custody.

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

Notes:

Documents Reviewed:

PIDC Policy 3.4.2 – Administrative Segregation
PIDC Policy 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 28 – Memorandum – No involuntary placement in Protective Custody

(a): PIDC Policy 3.4.2 and PIDC Policy 4.5.13 "allows for a detainee who is vulnerable to sexual abuse or assault to be placed on administrative segregation." The policy specifies "on admission to the Special Management Unit (SMU), the admitting official will complete an admission form and other documentation required to justify the reasons for the detainee's removal from general population." During the Remote Interview phase, the Acting Facility Administrator explained that alleged victims or detainees vulnerable to sexual abuse or assault, and those that require special housing, are usually placed in the MHU and/or the infirmary. Detainees at-risk of sexually abusing other detainees are placed on administrative segregation; she

further stated there were no detainees that required special housing during the audit period.. The facility provided a memorandum stating there have been no involuntary placements of detainees in protective custody. The facility policies were approved by the FOD on February 12, 2020.

While on-site, the Auditors determined individualized decisions are made regarding the housing of alleged victims. Alleged victims are not automatically placed in MHU or SHU following an allegation of sexual abuse. For example, the allegation reviewed during the site visit stated the detainee victim felt safe returing to her housing area and was returned.

(b)(c): PIDC Policy 4.5.13 states, "Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at PIDC, the facility will consult with the FOD for additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment will not ordinarily exceed a period of 30 days."

PIDC Policy 3.4.2 states, "Ordinarily, detainees in administrative segregation will be provided the same general privileges as detainees in the general population, in a manner consistent with the special safety and security requirements of detainees in these units. Services and programs generally include recreation (indoor-outdoor), showers, case management services, leisure, and legal library services via a unit-based or delivery service, access to a commissary or vending machines, religious counseling and materials, social and legal correspondence, phone calls, and visitation. When space and resources are available, detainees in administrative segregation will be able to participate in television viewing, board games, socializing, and work details (e.g., an orderly in the SMU); and provided opportunities to spend time outside of their cells, over and above standard recreation periods when possible." There were no detainees placed in protective custody.

Interviews with the PSA Compliance Manager and the Contract Quality Control Manager confirmed alleged victims are not automatically placed in the MHU or the SHU following an allegation of sexual abuse; although detainees may be temporarily placed in MHU during the initial investigation process, individualized decisions are made for housing of alleged victims that includes consideration of the detainee's opinion of their safety. While on-site, the Auditors reviewed one allegation that was received since the Remote Interview phase. This detainee shared (for the first time) that she was transgender. The detainee felt safe returning to her housing unit and was allowed to return.
(d)(e): PIDC Policy 3.4.2 states, "Within 72 hours of a detainee's initial placement in administrative segregation, a Contract Security Shift Commander or designee will conduct a review to determine if administrative segregation is still warranted. The status of all detainees will be reviewed by a Contract Security Shift Commander after the detainee has spent 7 days in administrative segregation, and every week thereafter, for the first 30 days and every 10 days thereafter, at a minimum. This review, and all subsequent segregation reviews, must include an interview with the detainee and must be documented on the Administrative Segregation Review Form I-885. The OIC, AOIC, AFOD, or designee will review the results of all reviews and may, if circumstances warrant, issue an alternate decision. If a detainee has been segregated for his or her own protection, but not at the detainee's request, the signature of the OIC, AOIC, AFOD, or designee is required on the I-885 Form to authorize continued segregation."

Interviews with the Acting Facility Administrator and AhtnaSTS Project Manager confirmed there were no detainees at risk for sexual victimization housed in administrative segregation. Both stated the detainees could be housed in the 30-bed MHU. There were no detainees at risk for sexual victimization placed on protective custody during the auditing period.

The facility meets the requirements of this standard.

§115.51 - Detainee reporting.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 29 – Listing of available free calls for detainees
Exhibit 30 – ICE PREA Poster

(a)(b): PIDC Policy 4.5.13 states, "Detainees will have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse or assault, and/or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting. Available methods of communication include but are not limited to verbal reports to any staff member (including the PSA Compliance Manager or medical staff), written informal or formal requests or grievances to the facility; sick call requests; report to an individual, organization or through a third party such as a relative or friend who can contact facility staff; written informal or formal requests or grievances (including emergency grievances) to the ICE Field Office; telephone calls or written reports to the DHS/OIG, ICE/OPR JIC, or ICE/DRIL; and telephone calls or written reports to consular officials." Information about reporting is also provided in the facility's and the ICE National Detainee Handbooks.

The facility provided the DHS poster listing of numbers for contacting consulate officials that are free calls to detainees that is posted in all housing areas. Listed on the poster are phone numbers that are free of charge, instructions for making a free call, and consulate contact information. The Auditors tested the DRIL, OPR, OIG, and JIC hotlines and found each would accept an anonymous report of sexual abuse.

The facility also provided a copy of the DHS OIG poster in English and Spanish, posted in the detainee housing area and common areas that provides information, to detainees, about how to report sexual abuse. The options include the PSA Compliance Manager, the ICE/DRIL and the DHS OIG number, where reports can be made anonymously. The PSA Compliance Manager, security staff, and detainees all confirmed this information is available to detainees in their housing areas. The Auditors toured all housing areas (not on cohort status) and program areas. The DHS OIG (English and Spanish, the DHS prescribed Sexual Abuse Awareness Information pamphlet, and information for contacting community organizations were all posted.

The Auditor reviewed the method of reporting for each of the six PREA investigations and found five detainees reported to staff (one to medical staff, one to mental health, and three to security staff) and one allegation was received through a third party (a letter from the detainee's lawyer).

(c): The PSA Compliance Manager and security staff interviewed confirmed that detainees may make reports of sexual abuse verbally, in writing, anonymously, through a third party, or by submitting a grievance. The security staff reported all allegations of sexual abuse are documented.

Detainees interviewed confirmed the postings in the housing areas and the alternatives means available for reporting sexual abuse or assault to include filing a grievance. Of the six investigation files reviewed, five reports were made to staff at the facility and staff reported the allegations timely and documented.

The facility meets the requirements of this standard.

§115.52 - Grievances.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 8 – Facility Detainee Handbook
Exhibit 31 – Memorandum – One grievance submitted related to sexual abuse

(a)(b)(c)(e): PIDC Policy 4.5.13 states, "Formal grievances related to sexual abuse and assault may be filed at any time during, after, or in lieu of lodging an informal grievance or complaint and with no time limit imposed on when a grievance may be submitted. A grievance that involves an immediate threat to a detainee's health, safety, or welfare related to sexual abuse or assault will be responded to as an emergency grievance. Immediate notification must be made to an ICE Supervisor on duty who will in turn notify the OIC, AOIC, or AFOD as needed. Emergency grievances not resolved at the shift level will be forwarded up the chain of command in a timely matter until the matter is resolved. Decisions on grievances will be issued within 5 days of receipt and appeals will be responded to within 30 days. All grievances related to sexual abuse and the facility's decision on any such grievance must be forwarded to the FOD." The Auditor further confirmed the practices mentioned above through an interview with the facility Grievance Officer.

The Grievance Officer confirmed that detainees can utilize the grievance system to make a sexual abuse report. He confirmed there are no time limits for when a detainee can file a grievance related to sexual abuse. He further explained that if he received a grievance related to sexual abuse, he would immediately contact the captain and medical, and separate the detainees. He also added he would ensure any available evidence was preserved. Additionally, the grievance officer would contact the PSA Compliance Manager concerning any sexual abuse related grievance. He stated decisions on sexual abuse grievances are issued within five days, but he was unsure about time limits related to grievance appeals.

During the Pre-Audit phase, the Auditor reviewed a memorandum from the Deputy FOD (DFOD) stating there had been one grievance filed related to sexual abuse. Although, the grievance was filed outside the audit period, it was reviewed on-site to determine if the processing of the grievance conformed to applicable standards. During the on-site phase, the Auditor reviewed the grievance and found the grievance was immediately forwarded to the PSA Compliance Manager and a decision was issued within five days of receipt of the grievance. This investigation of this allegation was outside the audit period, was not reviewed, and is not included in the investigations reviewed for this audit period.

The Auditor asked 30 detainees if they were aware a detainee could file a grievance related to sexual abuse and 25 detainees responded affirmatively, 5 detainees were not aware.

(d): All security staff interviewed confirmed that if they received a grievance related to sexual abuse, they would immediately separate the alleged victim, contact their supervisor, provide the grievance to the supervisor, and have the detainee seen by medical staff. Several security staff commented they never see grievances, and most were unaware of time limits related to the grievance system. Regardless, security staff knew to take immediate action to protect the victim and to seek assistance and medical attention.

(f): PIDC Policy 4.5.13 and the facility Detainee Handbook state, "Detainees may obtain assistance from another detainee, the Housing Unit Officer or other facility staff, family members, or legal representatives. Staff will take reasonable steps to expedite requests for assistance from these other parties." The Grievance Officer said he would assist a detainee to contact their family or lawyer to help the detainee prepare a grievance. Security staff interviewed had varied answers, but all reported they would assist the detainee or contact someone who could help the detainee write a grievance**.** The Auditors interviewed 30 detainees, of these detainees, 25 confirmed they knew they could obtain assistance to write a grievance, and all noted at least two sources of assistance (majority named a staff member or another detainee). There were five detainees who were not aware they could get assistance to write a grievance.

The facility meets the requirements of this standard.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does not Meet Standard (requires corrective action)Choose an item.

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 8 – Facility Detainee Handbook
Exhibit 9 – Poster titled Sexual Assault Victim Service Providers
Exhibit 12 – Memorandum - Detainee Access to Outside Confidential Support Services

(a)(b): PIDC Policy 4.5.13 states, "PIDC is in agreement with community service providers that offer legal advocacy and confidential emotional support services for immigrant victims of crime."

The facility provided a Memorandum from the DFOD stating the facility has agreements with three local community service providers: Friendship of Women, Inc., Family Crisis Center, Inc., and Women Together/Mujeres Unidas, who provide expertise and support for detainees in areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators. The PSA Compliance Manager confirmed the facility has agreements with these organizations as well. He stated the services provided by the community service organizations include crisis intervention and emotional support. The PSA Compliance Manager further noted that these organizations will accompany a detainee to court. He confirmed that the names, addresses, and phone numbers are provided on postings in the housing areas and in the local detainee handbook but stated the calls to these organizations are recorded.

The Auditor asked to review the agreements with the community service providers, but the agreements were not provided. The Auditor spoke with representatives from two of the organizations: Women Together/Mujeres Unidas and Family Crisis Center, Inc. They confirmed they provide crisis intervention and counseling services to detainees. The Women Together/Mujeres Unidas reported they will provide an advocate during the court proceedings. The Family Crisis Center, Inc. reported, prior to the nation-wide pandemic, the facility would bring detainees to their facility for in-person services. The Auditor attempted to contact the third organization, Friendship of Women, Inc., and left messages with no response. The Auditor determined community organizations do provide services for the facility through informal agreements between the facility and at least two of these organizations provide crisis intervention and counseling services to detainees. Following the Remote Interview phase, the ICE PSA Compliance Manager stated he is pursuing formal agreements with these organizations. During the on-site visit**,** the Auditor asked to review any signed MOU's or (MOA's) Memorandum of Agreement between the facility and the above-mentioned community organizations and found that the new ICE PSA Compliance Manager was not aware of this requirement. The ICE PSA Compliance Manager forwarded emails attempting to contact each organization immediately following the on-site visit.

(c)(d): The facility also provided a copy of a posting in the detainee housing area titled Sexual Assault Victim Service Providers. The posting provides the name of the community organization, phone number, hotline number, and website. The posting does not address confidentiality. The facility provided a copy of excerpts from the detainee handbook which states detainees can report sexual abuse to an outside organization, but it does not address whether these calls are confidential. Of the 30 detainees interviewed during the audit, 13 detainees did not know of these organizations. The remaining detainees were aware of the community organizations but were unsure what services these organizations provide. The Auditor reviewed six investigations during the audit period and found only one instance in which an alleged victim was provided information (pamphlet) about the community organizations.

Does Not Meet (d): The facility must inform detainees prior to giving them access to outside resources, of the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws and must provide information to alleged victims about these community organizations. The facility must develop a process to inform detainees prior to giving them access to outside resources, of the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws and must provide information to alleged victims about these community organizations and provide this information to the detainee population. Staff training must be conducted on the process. The facility must provide the process, documentation on how detainees are informed, and the documented staff training for compliance review.

The facility does not meet the requirements of this standard.

§115.54 - Third-party reporting.

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

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Exhibit 30 – ICE Zero Tolerance Poster
Exhibit 32 – DHS OIG Reporting Poster

PIDC Policy 4.5.13 states, "PIDC will establish a method to receive third-party reports of sexual abuse in its facility and will make available to the public information on how to report sexual abuse on behalf of a detainee." The ICE Zero-Tolerance Poster, which is posted in the housing areas, provides numbers for the DRIL and the DHS OIG. Anonymous calls can be made to the OIG. The DHS OIG Poster provides information to employees and the public to report suspected criminal violations, misconduct, wasteful activities, and allegations of civil rights or civil liberty abuse. An address and phone number are provided, and complaints can be made anonymously and confidentially. Reporting information is also provided on posters in the visitiation area.

The ICE website (www.ice.gov/prea) provides the addresses and phone numbers for the OIG; the phone number and information about submitting a complaint on-line through the ICE ERO; and the phone number and email address for reporting sexual abuse complaints through the ICE OPR**.**

There was one sexual abuse investigation reviewed in which a third party (lawyer) made a complaint of sexual abuse. The facility accepted the report and immediately began an investigation. During the on-site visit**,** the Auditors were advised there were no additional third-party reports of sexual abuse allegations since the Remote Interview phase.

The facility meets the requirements of this 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:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention

(a)(b): PIDC Policy 4.5.13 states, "Staff must report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in the facility; retaliation against detainees or staff that reports, complains about, or participated in an investigation about sexual abuse or assault; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff must also be able to report incidents of sexual abuse outside of the chain of command and accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." The facility policy requires all employees to attend initial and refresher training on the facility's SAAPI program. The policy requires the training to include instruction on reporting knowledge or suspicion of sexual abuse and/or assault and making intervention referrals to the facility's program. The facility policies were reviewed and approved by the FOD on February 12, 2020.

The PSA Compliance Manager confirmed that staff are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse and retaliation against detainee or staff, or staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. He added staff would be disciplined for failure to report any of the above. He also stated staff are aware that they can report outside the chain of

command any of these incidents to PSA Compliance Manager. The security staff interviewed were aware of their responsibilities and would immediately follow the facility's reporting requirements.

The Auditors reviewed six allegations and found five of the reports of sexual abuse were made to staff and one report was received through a third party. The staff members receiving the reports responded appropriately by reporting to supervisors, ensuring the alleged victim was separated, and documenting the incident.

(c): PIDC Policy 4.5.13 states, "Information concerning the identity of a detainee victim reporting a sexual assault, and the facts of the report itself, will be limited to those who have a need-to-know in order to make decisions concerning the detainee-victim's welfare and for law enforcement/investigative purposes. Apart from such reporting, staff will not reveal any information related to a sexual abuse and assault report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions." Security staff interviewed were also aware that information regarding these incidents is on a need-to-know basis.

(d): The section of the standard is not applicable. The facility does not house juveniles or family units. There were no vulnerable adults housed at the facility during the audit period, based on staff interviews.

The facility meets the requirements of this standard.

§115.62 - Protection duties.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention
Sexual abuse investigations

PIDC Policy 4.5.13 states, "All staff and detainees are responsible for being alert to signs of potential situations in which sexual assaults might occur, and for making reports and intervention referrals as appropriate. If a staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she will take immediate action to protect the detainee."

The Facility Administrator stated if a staff member has a reasonable belief that a detainee is at-risk of imminent sexual abuse, they should immediately contact their supervisor, ensure the detainee is taken to medical, and notify ICE through the chain of command. Security staff consistently reported they would immediately separate the detainee and contact their supervisor.

The Auditors reviewed six investigations during the audit period. Five of the allegations were reported to staff and one report was made through a third party. Staff responded appropriately ensuring the alleged victim was safe and separated from the alleged victim.

The facility meets the requirements of this standard.

§115.63 - Report to other confinement facilities.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 33 – Memorandum – Reporting to Other Confinement Facilities

(a)(b)(c): PIDC Policy 4.5.13 states, "Upon receiving an allegation that a detainee was sexually abused or assaulted while confined at another facility, the OIC, AOIC, or AFOD will notify the FOD and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The OIC, AOIC or AFOD will notify the detainee in advance of such reporting. PIDC will document that it has provided such notification. The facility will ensure the allegation is referred for investigation and reported to the FOD."

The facility provided a memorandum from the DFOD stating in the year preceding the audit, PIDC has no record of a detainee reporting allegations of sexual abuse at another confinement facility after transferring to the PIDC. If PIDC received notification from a detainee that a sexual abuse or assault occurred at another facility, the detainee would be immediately referred to IHSC. If necessary, emergency medical care would be rendered. If applicable, IHSC would refer the victim to the VBMC or forensic evidence collection. Once the detainee is discharged, a full medical and mental health evaluation will be performed. All necessary referrals will be initiated. The Facility Administrator and PSA Compliance Manager confirmed this would be the facility's response. During the on-site visit, the facility reports there had been no incidents of a detainee reporting allegations of sexual abuse while at another facility.

(d): The ICE PSA Compliance Manager stated if the facility received a report from another facility of an alleged incident of sexual abuse that occurred at the PIDC he would immediately notify OPR and refer the allegation for investigation; the FOD would also be notified and these notifications would occur within 72 hours. There have been no such reports during this audit period.

The facility meets the requirements of this standard.

§115.64 - Responder duties.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 34 – Memorandum – 1st Responder Reports

(a)(b): PIDC Policy 4.5.13 states, "The staff member who first identifies or suspects that a detainee has been abused or an assault may have occurred should refer the matter to their immediate supervisor, investigative supervisor, or designee. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder will preserve and protect to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder is not a security staff member, the responder will request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff."

The Auditor determined security staff was knowledgeable about their responsibilities regarding allegations of sexual abuse. Security staff consistently reported they would separate the alleged victim, notify their supervisor, preserve the crime scene, and instruct detainees not to take actions that could destroy evidence. Non-security staff interviewed reported they would separate the victim and the alleged abuser, call their supervisor, and secure the crime scene.

Of the six PREA allegations reviewed, five reports were made from detainees to first responders. Each responder ensured the alleged victim was safe, immediately notified supervisory staff and remained with the victim until security supervisors arrived.

The facility meets the requirements of this standard.

§115.65 - Coordinated response.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 35 – Memorandum – Coordinated Response

(a)(b): PIDC Policy 4.5.13 outlines the facility's coordinated response plan to allegations of sexual abuse or assault. The response plan includes response to sexual abuse incidents, procedures for investigations, the medical assessment of the victim, forensic examinations, mental health services, and monitoring and follow-up. The policy outlines the roles and responsibilities of the facility staff, investigators, medical and mental health providers, SAFE/SANE trained examiners, and the agency in responding to an incident of sexual abuse or assault. The Acting Facility Administrator explained that the initial responders notify their supervisors of the incident. Supervisory staff ensure the detainee is taken to medical, and they also notify the ICE OPR investigators of the incident.

The Auditor reviewed six allegations that occurred during the audit period. The coordinated response plan was implemented in each case, except for one. In this case, an allegation was received but the facility investigator determined the matter was not PREA related, after conducting an internal investigation. Tne allegation should have been reported to JIC. When an allegation was received, the security supervisor was advised, the alleged victim was separated from the alleged abuser, taken to medical for examination, seen by mental health staff (usually the same day). There were no incidents that required a forensic examination, but these services are available if needed. One allegation was referred to the CCSO, who refused the investigation.

(c)(d): PIDC Policy 4.5.13 states if a victim is transferred between detention facilities, the sending facility will, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility). If the receiving facility is unknown to the sending facility, the sending facility will notify the FOD, so that he or she can notify the receiving facility.

The Acting Facility Administrator explained that typically they do not transfer alleged victims until the investigation is closed. She explained that if the victim was transferred, the receiving facility would be notified about the investigation and the detainee's need for possible medical or mental health care, if needed. The same would occur if the victim was transferred to a non-DHS facility, except the victim would have to approve. During the audit period**,** the Auditors were advised by the Deputy FOD the facility did not transfer a detainee victim between detention facilities.

The facility meets the requirements of this 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:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Sexual Abuse Investigations

PIDC Policy 4.5.13 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse or assault will be removed from all duties requiring detainee contact pending the outcome of an investigation. Where a contractor is alleged to be the perpetrator, the contractor's firm will also be notified of the incident."

The AhtnaSTS Project Manager stated that if an employee was accused of sexual abuse, the employee would be assigned to posts that do not have detainee contact. If the information was considered reliable, the employee may be placed on administrative leave. He reported that ICE investigators would handle sexual abuse allegations involving staff, volunteers or other contractors. The Acting Facility Administrator explained that if contract staff are suspected of sexual abuse or assault, they would be removed from contact with detainees. Volunteers suspected of sexual abuse or assault would not be allowed to return to the facility, until the investigation is completed.

The Auditor reviewed six investigations, all of which were detainee-on-detainee allegations. There were no allegations of sexual abuse by staff, volunteers, or contractors during the audit period.

The facility meets the requirements of this standard.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action) Choose an item.

Notes:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 36 – Memorandum – Agency Protection Against Retaliation

(a)(b)(c): PIDC Policy 4.5.13 requires employees, contract staff and volunteers to receive initial and annual SAAPI training. This training includes the right of detainees and staff to be free from sexual abuse and agency prohibitions on retaliation against detainees and staff who report sexual abuse and PIDC will employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainee or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations.

PIDC Policy 4.5.13 states, "PIDC will employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainee or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. For at least 90 days following a report of sexual abuse or assault, PIDC will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and will act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments by staff. The facility will continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need."

The facility provided a memorandum from the AFOD stating there have been no reports of detainee or staff retaliation related to sexual abuse/assault incidents in the audit period. The Acting Facility Administrator stated it is important for staff responsible for retaliation monitoring to maintain an open line of communication with detainees and to monitor any program changes or incident reports. She also stated when monitoring staff for retaliation an open line of communication must be maintained with the staff member and absences, negative performance reviews, and post assignment changes should be monitored. The PSA Compliance Manager stated detainees would be monitored for retaliation for as long as they are in the facility. The AhtnaSTS Project Manager stated the facility Captains monitor for retaliation, but he was unclear if the retaliation monitoring was documented. The ICE PSA Compliance Manager indicated the facility would monitor both staff and detainees for any retaliation, including monitoring for as long as the detainee is at the facility. There were no detainee victims at the facility during the interview phase of the audit.

The Auditors reviewed five investigations during the pre-audit phase and one investigation during the on-site phase. There was no record of retaliation monitoring for any six investigations reviewed. The Auditor verified one alleged victim was released two days after making the sexual abuse allegation, so there was no record of retaliation monitoring. The facility could not verify retaliation monitoring occurred for any of the six alleged victims (or witnesses when applicable).

Does Not Meet (c): Retaliation monitoring could not be verified for any of the alleged victims. The facility must be able to demonstrate alleged victims (and witnesses when applicable) are monitored for retaliation immediately following an allegation of sexual abuse. The facility must develop a process to ensure retaliation is initiated and monitored for at least 90 days following an allegation of sexual abuse. The facility must provide training to staff responsible for monitoring retaliation. The facility must provide the process, documented staff training, and five examples of retaliation monitoring, if available.

The facility does not meet the requirements of this standard.

§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:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 37 – Memorandum – Post Allegation Protective Custody

(a)(b): PIDC 4.5.13 states, "Care must be taken not to punish a confirmed or alleged sexual assault victim. Victimized detainees should not be subject to disciplinary action either for reporting sexual abuse or for participating in sexual activity as a result of force, coercion, threats, or fear of force. Care will be taken to place the detainee in a supportive environment that represents the least restrictive housing option possible (e.g., protective custody), and to the extent possible, permit the victim the same level of privileges he or she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical and mental health needs of the alleged victim. However, victims will not be held for longer than 5 days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee."

During the Remote Interview phase, the PSA Compliance Manager stated usually detainee victims are housed in the MHU. He further stated detainee victims are never placed in administrative segregation. There were no detainee victims available for interview during the Remote Interview phase. There was one detainee victim interviewed during the on-site phase. The detainee revealed he was transgender during a session with mental health staff and also reported an allegation of sexual abuse. The detainee was held in the medical area during the investigation as a protective measure, but not on administrative segregation status. Following the investigation, the alleged victim was returned to her housing unit after stating that she felt safe to do so.

(c)(d): PIDC Policy 4.5.13 states, "A detainee victim who is in protective custody after having been subjected to sexual abuse will not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault. The policy also states PIDC will notify the FOD whenever a detainee victim, or detainee considered to be vulnerable to sexual abuse or assault has been held in administrative segregation for 72 hours."

The PSA Compliance Manager confirmed that detainee victims are reassessed before they are returned to the general population. He stated victims are not placed in administrative segregation as detainee victims are housed in the MHU or the infirmary. He also confirmed that ICE FOD would be notified

if a victim was placed in administrative segregation. The Acting Facility Administrator confirmed the detainee is reviewed after 72-hours and she is notified via email of the 72-hour review. This information is also forwarded to the ICE FOD. None of the detainee victims involved in the six PREA investigations reviewed were placed in protective custody. Typically the alleged victim is housed in medical during the investigation or longer if needed, but are not on administrative segregation status. For the investigation reviewed on-site, the alleged victims returned to their regularly assigned housing area and stated they had no concerns about returning to housing area. Additionally, there were no detainees in segregation due to risk of sexual victimization.

The facility meets the requirements of this standard.

§115.71 - Criminal and administrative investigations.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention

(a): PIDC Policy 4.5.13 states, "If a detainee alleges sexual assault, a sensitive and coordinated response is necessary. All investigations into alleged sexual assault must be prompt, thorough, objective, fair and conducted by qualified investigators. The program coordinator will be responsible for reviewing the results of every investigation of sexual abuse. When possible and feasible, appropriate staff will preserve the crime scene, and safeguard information and evidence in coordination with the referral agency and consistent with established evidence gathering and processing procedures." Criminal investigations are referred to the Cameron County Sheriff's Office (CCSO). One case was referred to the CSSO, but the detainee declined to pursue criminal charges. The PAQ, ICE OPR investigator, and the PSA Compliance Manager confirmed that ICE OPR conducts investigations of sexual abuse allegations and the CCSO is responsible for conducting criminal investigations of PREA allegations. The security contractor, AhtnaSTS, employs a trained administrative investigator who completes administrative investigations. The Auditor verified the ICE OPR investigators and administrative investigator each completed specialized training in conducting PREA investigations. The facility submitted documentation that confirmed security captains are also conducting PREA fact-finding activities, i.e., interviewing staff, and detainees, gathering statements, monitoring recorded videos, and determining whether the alleged incident is, in fact, a PREA-related matter. The Auditors determined this training provides sufficient training for staff who serve in the role of fact finders.

(b): PIDC Policy 4.5.13 states," Designated staff will provide services to victims and will conduct an internal administrative investigation of sexual abuse or assault incidents only after consultation with ICE OPR or after a criminal investigation has concluded. Such procedures will establish the coordination and sequencing of the two (2) types of investigations, to ensure that the criminal investigation is not compromised by an internal administrative investigation."

During the Remote Interview phase, the Auditor received conflicting information regarding the completion of administrative investigations. The ICE OPR investigator reported his office conducts the initial investigation, and will at times, refer the investigation back to the facility to conduct an administrative investigation, if his office and the CCSO decline to pursue the investigation. He explained the case would be referred to the ICE PSA Compliance Manager, who would conduct an administrative investigation. The ICE PSA Compliance Manager reported he is not a trained investigator and does not complete administrative investigations. He further stated the facility did not have a trained administrative investigator. However, the Auditor determined, through an interview with the Project Manager for AhtnaSTS, that a trained administrative investigator is employed by AhtnaSTS to complete administrative investigations of PREA complaints. The Auditor requested and reviewed the contract between the facility and AhtnaSTS which confirmed AhtnaSTS would conduct administrative investigations. The contract Investigator was interviewed and confirmed he completed administrative investigations. The Auditors also confirmed he has sufficient training to conduct administrative investigations of sexual abuse allegations.

During the on-site phase, the Auditor met with the ICE PSA Compliance Manager and Contract PSA Compliance Manager/investigator and discussed changes the facility had implemented regarding administrative investigations. All parties are now aware of the process for completing and sharing of information in the administrative investigation. This information is also shared with the Sexual Abuse Incident Review boards.

(c): PIDC Policy 4.5.13 also states, "The Administrative Investigator will interview and obtain written statements from the alleged victim, alleged perpetrator, and witnesses. The preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data will be collected. Review prior complaints and reports of sexual abuse or assault involving the suspected perpetrator. Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph. The Administrative Investigator will determine whether actions or failures to act at the facility contributed to the abuse. Documentation of each investigation by written report will include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years."

The facility had six allegations reported in the audit period. The Auditor found the administrative investigations completed by the contract Investigator to be well written and thorough. The administrative investigation report described the evidence, assessed the witnesses' credibility, reviewed past complaints and past criminal histories, and provided recommendations and well-supported findings to the facility.

(e): PIDC Policy 4.5.13 states, "The departure of the alleged abuser or victim from employment or control of the facility will not provide a basis for terminating an investigation." Interviews with the Acting Facility Administrator, the contract Project Manager, the ICE PSA Compliance Manager, and contract facility investigator all confirmed that an investigation would continue even if the alleged abuser or alleged victim left employment or were no longer under control of the facility.

(f): PIDC Policy 4.5.13 states, "When outside agencies investigate sexual abuse and assault, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation." The ICE PSA Compliance Manager as well as the investigators confirmed that the facility cooperates with outside investigators and the ICE PSA Compliance Manager stays informed about the progress of the investigation.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention

PIDC Policy 4.5.13 states, "The facility uses no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated."

Three administrative investigations conducted by the contract PSA Compliance Manager/Investigator were reviewed by the Lead Auditor. Two of the investigations included the term, "a totality of the evidence." This is a higher standard of proof than a preponderance of the evidence. During the on-site visit, the Auditor informally interviewed the contract PREA investigator/PREA Compliance Manager. He understood the requirement to require no standard of proof higher than the preponderance of the evidence. Interviews with all investigators confirmed that they all are aware the administrative investigations require no standard greater than a preponderance of the evidence.

Recommendation: It provides further support for this standard and for other reviewing officials for the administrative investigator to note the standard of proof applied to a specific investigation.

The facility meets the requirements of this standard.

§115.73 - Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

Exhibit 38 – Memorandum – Reporting to Detainees

The Facility Administrator confirmed that detainees are notified of the results of the investigation. The PSA Compliance Manager explained that ICE notifies the detainees of the results of the investigation and the facility is provided a copy of the notification. He explained that detainees usually are at the facility for only 15-20 days. If the detainee provided a forwarding address, the notification would be sent to the detainee. Copies of the notifications are maintained in the facility's investigation files, as observed by the Lead Auditor during file reviews. There were six investigations reviewed during the audit period. One investigation was open, and one allegation was not reported to JIC, so the agency did not close the investigation for the unreported case and notify the detainee of the results of the investigation. Of the remaining four investigations, one detainee was provided notification of the results of the investigation. Two investigation files included a copy of the Notification from ICE, but the form was unsigned by detainee or staff and the Auditor was unable to confirm if the detainee victim was provided with notification of the results of the investigation or the reason for which the detainee was unable to be notified. One detainee was told the abuser was issued a disciplinary infraction and housed in SMU, but he was not notified the allegation was substantiated.

Does Not Meet: The agency/facility did not provide consistent notification to the alleged victim of the outcome of the investigation. The agency/facility must ensure every effort is made to notify the alleged victims of the results of the investigation while they are still in immigration custody, or when otherwise feasible. The agency must develop a process to ensure notifications are provided to all detainees of the result of the investigation and any responsive action taken. Agency staff responsible for making notifications must be trained on the process. The agency must provide the process, documented staff training, and two examples of notifications made to a detainee for compliance review.

The facility does not comply with this 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:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention

Exhibit 39 – Memorandum – Disciplinary Sanctions for Staff

(a)(b): PIDC Policy 4.5.13 states, "Staff will be subject to disciplinary or adverse action up to and including removal from their position and Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse rules, policies, or standards. Removal from their position is the presumptive disciplinary sanction for staff member, contractor, or volunteer who have engaged in or attempted or threatened to engage in those acts of sexual abuse defined (in the policy)." The facility policy was approved by the FOD on February 12, 2020. The DFOD provided a memorandum stating the PIDC has no record of termination, resignation, or other sanction against staff members for violating agency sexual abuse/assault policies during the audit period.

The Acting Facility Administrator confirmed that staff are subject to disciplinary and adverse action up to and including removal from their position for substantiated allegations of sexual abuse. She also noted if the staff member was a security staff, the facility would notify ICE. For medical and mental health staff, the medical licensing board or social work licensing board would be notified of the abuse. The AhtnaSTS Project Manager confirmed that law enforcement would be notified of any staff removals or resignations in lieu of removal for incidents of substantiated sexual abuse.

(c)(d): PIDC Policy 4.5.13 states, "PIDC will report all incidents of substantiated sexual abuse by staff, and all removals of staff, or resignations in lieu of removal for violations of agency or facility sexual abuse policies, to appropriate law enforcement agencies unless the activity was clearly not criminal. The facility will also report all such incidents of substantiated abuse, removals or resignations in lieu of removal to the FOD, regardless of whether the activity was criminal, and will make reasonable efforts to report such information to any relevant licensing bodies, to the extent known." The facility reported there were no sexual abuse reports of staff–on-detainee sexual abuse or assault during the audit period. The Acting Facility Administrator confirmed for medical and mental health staff, the medical licensing board or social work licensing board would be notified of the abuse. There were no staff-on-detainee allegations during the audit period.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 40 – Memorandum – Corrective Action for Volunteers

(a)(b)(c): PIDC Policy states, "Any contractor or volunteer who has engaged in sexual abuse or assault will be prohibited from contact with detainees. The facility will take appropriate remedial measures and will consider whether to prohibit further consider whether to prohibit further volunteers who have not engaged in volunteers who have not engaged in other sexual abuse policies."

The DFOD provided a memorandum stating PIDC did not identify any incidents of a contractor/volunteer violating sexual abuse/assault policies at the PIDC in the audit period. The Acting Facility Administrator stated if a contractor or volunteer was alleged to have been involved in the sexual abuse of a detainee, the contractor or volunteer would be removed from contact with any detainees until the completion of the investigation. If the investigation revealed potentially criminal activities, local law enforcement would be notified. During the on-site visit phase, the Auditor reviewed investigations and confirmed there were no incidents of a contractors or volunteers violating sexual abuse policies.

The facility meets the requirements of this 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:

Documents Reviewed:

PIDC Policy 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Facility Detainee Handbook
Exhibit 41 – Memorandum – Disciplinary Sanctions for Detainees
PIDC Policy 3.4.2 – Administrative Segregation
PIDC Policy 3.3.1 – Detainee Discipline

(a)(b): PIDC Policy 4.5.13 states, "Detainees will be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault." PIDC Policy 3.3.1 outlines the disciplinary process and the offenses with the sanctions. The Auditor requested and reviewed excerpts from PIDC Policy 3.4.2 and local detainee handbook which also outlines behaviors that are subject to discipline sanctions as well as the possible sanctions for the violations. The policy specifies sexual abuse and harassment infractions and the potential sanctions.

(c): PIDC Policy 3.3.1 outlines the progressive levels of reviews, the appeal process, and documentation requirements of the discipline process. The policy also addressed the standard requirement that at all steps in the disciplinary process any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. Disciplinary Procedures outlines prohibited acts of conduct and sanctions, which are broken into offense categories of Greatest (sexual assault), High (engaging in sexual acts, making sexual proposals or threats), High Moderate, and Low Moderate. The handbook outlines the detainee can appeal the decision of the Disciplinary Officer within seven days using the grievance procedure. The Acting Facility Administrator and AhtnaSTS Project Manager confirmed there are progressive levels of appeals.

(d): PIDC Policy 4.5.13 states, "If a detainee is mentally disabled or mentally ill but competent, the disciplinary process will consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed." If it appears at any stage of the disciplinary process that a detainee is mentally ill or mentally incompetent, the Contract Security Shift Commander will refer the detainee to the health clinic for a mental health assessment. Staff may take no disciplinary action against a detainee whom IHSC staff determines to be incompetent or not responsible for his conduct." The Acting Facility Administrator and AhtnaSTS Project Manager confirmed medical staff are part of the disciplinary review and assess detainees placed in segregation to determine whether the detainee's mental illness may have contributed to the infraction.

(e): PIDC Policy 4.5.13 states, "The facility will not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact." The Acting Facility Administrator stated a detainee would not be disciplined for consensual sex with a staff member.

(f): PIDC Policy 4.5.13 states, "For the purpose of disciplinary action, a report of sexual abuse or assault made in good faith based upon a reasonable belief that the alleged conduct occurred will not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The Acting Facility Administrator confirmed a detainee would not be disciplined for making a report of sexual abuse in good faith.

There was one substantiated detainee-on-detainee allegations during the audit period. The facility provided a memorandum from the DFOD stating the PIDC has one record of a detainee determined to have engaged in sexual abuse/assault of another detainee in the year preceding the audit. During the on-site visit**,** the Auditor confirmed the abuser in the above incident was charged and found guilty of violating the facility sexual abuse rules and was sentenced to 20 days in SMU.

The facility meets the requirements of this standard.

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

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

Notes:

Documents Reviewed:

IHSC 03-01 Intake Screening and Intake Reviews
PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 42 – Memorandum - Medical and Mental Health Assessments History of Sexual Abuse
Detainee Medical Records (8)

(a)(b)(c): Medical staff are responsible for completing a potion of the risk assessment for detainees and intake staff gather other information related to assessing a detainee's risk of victimixation. . IHSC Policy 03-01 states, "behavioral health referrals are made in accordance with the IHSC Behavioral Health Services Guide. If a detainee discloses a history of sexual victimization or abuse during a medical or mental health intake screening, whether it occurred in an institutional setting or in the community, a referral to mental health or a Master Level Practitioner (MLP) should be made immediately." The HSA explained that the medical staff complete an initial screening of the detainee upon arrival at the facility. A more in-depth intake screening is then completed within 12 hours. PIDC Policy 4.5.13 states, "When a referral for mental health follow-up is initiated, the detainee will receive a mental health evaluation no later than 72 hours after the referral." The HSA and Mental Health provider confirmed detainees who report prior sexual abuse are referred to mental health staff for evaluation and are seen within 72 hours, but often the detainee is seen the same day. A referral to mental health staff was made in each of the medical records reviewed. All detainees were seen within 72 hours of the referral. There were no detainees who reported prior sexual abuse at the time of the Remote Interview phase and one detainee victim was interviewed during the on-site phase.

The Auditor reviewed eight detainee medical records. There was one case of a detainee who reported a previous sexual victimization during the intake phase. The detainee was referred to mental health staff and seen as required. In each of the eight cases, the detainee was seen by a medical provider within two days of referral by nursing staff. During the on-site visit, the Auditor reviewed one PREA investigation and interviewed the alleged victim. The detainee had a prior history of sexual abuse and was being seen by mental health staff. During an interview with mental health staff, the detainee reported sexual abuse by another detainee. She also divulged (for the first time) that she was transgender. The mental health staff contacted the supervisor and ensured the detainee remained in the medical area, away from the abuser, until security supervisors arrived. Medical staff was advised of the detainee's transgender status. The detainee was given the option to remain in the MHU but asked to be returned to her housing area. The detainee was returned to her country a couple of days following the report. The Auditor reviewed the medical risk assessment and confirmed the detainee did not identify as transgender to medical staff during the intake processing.

The facility meets the requirements of this standard.

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

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

Notes:

Documents Reviewed:

IHSC 03-01 Sexual or Physical Assault, Abuse and/or Neglect
Exhibit 43 – Memorandum - Access to Emergency Medical and Mental Health Services

(a)(b): IHSC Policy 03-01 states, "After an allegation of abuse, assault, or neglect, the alleged victim is seen by a health care provider for a medical evaluation. The health care provider evaluates the detainee and in collaboration with the Clinical Director (CD) and HSA refers all suspected assault, abuse, or neglect to the Behavioral Health Provider (BHP), physician, or qualified health care provider for a mental health evaluation. Appropriate medical and mental health interventions are conducted to meet the detainee's needs. When needed, the detainee is transferred to an outside facility for appropriate level of care and assessment. This may include a forensic medical evaluation involving the collection of evidence, using a kit approved by the proper authority, if necessary. Victims of sexual abuse shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis."

The HSA reported all emergencies are seen immediately by medical staff and if necessary, the alleged victim is transported immediately to the hospital. He added that medical and mental health care is provided to the detainee regardless of whether the alleged victim identifies the abuser or cooperates with the investigation. He said testing and treatment for sexually transmitted disease and pregnancy testing is provided by the medical department. The mental health staff interviewed also confirmed that alleged victims of sexual abuse are referred to mental health staff and are usually seen the same day and that there is an on-call mental health staff member available after hours. The facility provided a memorandum from the DFOD stating that the PIDC provides emergency medical/mental health services to any detainee victim in a timely manner and without cost to the detainee. Of the eight detainee medical files reviewed, three files were for detainees who were alleged victims of sexual abuse. The detainees were all seen immediately by medical staff and seen by mental health staff within 48 hours. There were no detainee victims of sexual abuse at the facility at the time on-site visit to interview or during the Remote Interview phase. During the on-site visit, the Auditor reviewed one investigation in which the detainee reported sexual abuse to mental health staff. The detainee was promptly referred to security supervisors and seen by medical staff.

The facility meets the requirements of this standard.

§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:

Documents Reviewed:

IHSC 03-01 - Sexual or Physical Assault, Abuse and/or Neglect
PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention

(a)(b)(c): IHSC Policy 03-01 states, "ICE has a zero-tolerance policy for any form of sexual abuse or assault. IHSC will provide immediate medical and mental health treatment to all detainees with a current and/or history of sexual abuse. All IHSC facilities must implement the following: provide emergency medical and mental health services to detainees who are victims of sexual abuse, services include initial evaluation; ongoing mental health care; examination; and referrals; evaluation and treatment of victims as appropriate; follow up services, treatment plans, and when necessary, referrals

for continued care following their transfer, placement in other facilities, or release from custody." The HSA stated the facility provides victims of sexual abuse mental health services, psychiatric evaluation and treatment if indicated, treatment plans, psychotherapy, treatment for sexually transmitted diseases (STD), pregnancy testing, and services through community providers. During the on-site visit phase, the Auditor reviewed one allegation of sexual abuse since the Remote Interview phase. The alleged victim was promptly referred to security supervisors and seen by medical staff.

(d)(e)(f)(g): PIDC Policy 4.5.13 states, "Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated will be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim will receive timely and comprehensive information about lawful pregnancy-related medical services. If available and offered by a community facility, prophylactic treatment, emergency contraception and follow-up examinations for sexually transmitted diseases will be offered to all victims, as appropriate. PIDC Policy 4.5.13 also states services are provided at no cost to the detainee, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The OIC, AOIC or AFOD will arrange for the detainee-victim to undergo a forensic medical examination. PIDC will 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 HSA confirmed these services are provided to the victims of sexual abuse at no cost to the detainee. Medical staff confirmed these services are provided to the victim regardless of the victim's willingness to participate in the investigation or name the abuser. A review of the eight detainee medical records and interviews with mental health staff confirmed abusers are seen by mental health and an assessment and counseling services are offered if the abuser is amenable. The Auditor reviewed eight medical files, six of which are alleged abusers or victims and found mental health staff interviewed each detainee and offered services. During the on-site visit phase**,** the Auditor reviewed one investigation, the alleged victim, who had a history of sexual victimization was being seen by mental health staff and reported the sexual abuse allegation during a session. Mental health staff continued counseling with the victim. The abuser was also seen by medical staff.

The facility meets the requirements of this standard.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention
Exhibit 45 and 46 – Memorandum - Sexual Abuse Incident Reviews and Reports

(a)(c): PIDC Policy 4.5.13 states, "PIDC will conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For any substantiated or unsubstantiated allegation, the facility will 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 and assault. PIDC will implement recommendations for improvement or document its reasons for not doing so in a written response. Both the report and response will be forwarded to the FOD, or his or her designee, for transmission to the PSA Compliance Manager. The facility will also provide any further information regarding such incident reviews as requested by the PSA Compliance Manager."

The Auditors reviewed six investigations during the audit period, five closed and one open. Sexual abuse incident review boards reviewed the four of the five closed investigations. There were no dates provided on the sexual abuse incident reports for the Auditor to confirm the reviews were conducted within 30 days of the conclusion of the investigation. The facility explained the dates of the Sexual Incident Reviews are in the facility's data base. The Auditor asked the facility to check the dates of the reviews and provide the information to the Auditor. The Auditor did not receive these dates.

Does Not Meet (a): The facility could not provide documentation that the sexual abuse incident reviews were completed within 30 days from the conclusion of the investigation. The facility must develop a method to capture the time frame of the review to ensure the review is completed within 30 days from the conclusion of the investigation. Staff must be trained on the timeframe requirement. The facility must provide the process to capture the incident review completion date, documented staff training, along with two examples of incident reviews completed in a timely manner for compliance review.

(b): The review team will consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The Sexual Abuse Incident Review reports do consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. All the reports indicated these factors were not motivating factors.

Recommendation: The Auditor noted that of the 5 alleged victims, 4 were under the age of 23. The facility should consider if this is a trend and if so, utilize the resources available at the facility through the mental health department to consider how the facility might address this issue and reduce other incidents of sexual abuse among this age group.

(c) PIDC Policy 4.15.13 states, "PIDC will conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility will prepare a negative report. The results and findings of the annual review will be provided to the OIC, AOIC or AFOD and FOD, or his or her designee, for transmission to the ICE PSA Coordinator." During the on-site visit, the annual review of sexual incident investigations was not provided, nor provided after the audit as requested for review.

Does Not Meet (c): The facility was unable to provide an annual review of any sexual abuse investigation. The facility must complete an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse investigation, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility should prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, Field Office Director (FOD)mor his or her designee and the agency PSA Coordinator. An annual review for all investigations should be conducted and submitted for compliance review.

The facility does not meet the requirements of this standard.

§115.87 - Data collection.

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

Notes:

Documents Reviewed:

PIDC 4.5.13 - Sexual Abuse and Assault Prevention and Intervention

(a): PIDC Policy 4.5.13 requires the OIC, AOIC, or AFOD to maintain all case records associated with claims of sexual abuse chronologically in a secure location. The policy states, "The OIC, AOIC, or AFOD will maintain a listing of the names of sexual assault victims and assailant along, with the dates and locations of all sexual assault incidents occurring within the facility, on his or her computerized incident reporting system. Such information will be maintained on a need-to-know basis in accordance with the detention standards on "Medical Care" and "Detention Files", which includes protection of electronic files from unauthorized access. At no time may law enforcement sensitive documents or evidence be stored at the facility. The OIC, AOIC, or AFOD will give assailant(s) and victim(s) involved in a sexual assault incident a specific designator as required in the official reporting system (SIR, SEN, or other). Access to this designation will be limited to those staff involved in the treatment of the victim or the investigation of the incident. The authorized designation will allow appropriate staff to track the detainee victim or assailant of sexual assault across the system. Based on the designated reporting data, the ICE/ERO program office will report annually the number of sexual assaults occurring within secure detention facilities utilized by ICE/ERO. Data will be provided through the SEN system. On an ongoing basis, the PSA Compliance Manager and facility administrator must work with the Field Office and ICE PSA Coordinator to share data regarding sexual abuse incidents and response."

The PSA Compliance Manager said the facility investigation files are stored in his office in a locked file cabinet. During the on-site visit, the Auditors confirmed facility investigations are stored in a locked file cabinet in the PSA Compliance Manager's PSA Compliance Manager office.

The facility meets the requirements of this standard.

§115.201 - Scope of audits.

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

Notes:

(d): During the on-site visit, the Auditors were given full access to all areas accessible to detainees, with the exception of the cohort pods.

(e): During the Pre-Audit and Remote Interview phases of the contingency audit, the Auditors reviewed all policies, memos, and other documents provided by the facility.. During the on-site visit of the audit, the Auditors reviewed additional compliance documentation, detainee, and staff files.

(i): Interviews with detainees conducted remotely through WebEx were conducted in private and remained confidential, as were the interviews conducted with staff via a conference line. The Auditor was provided with a private room to interview staff and detainees while on-site.

(J): The Auditors received no communication from detainees or staff.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	31
Number of standards not met:	7
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Margaret L. Capel 10/7/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 10/13/2021

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 10/7/2021

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Margaret L. Capel	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(479) 521-[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:	ICE/ERO San Antonio Field Office		
Field Office Director:	Jose M. Correa, Sr.		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1777 NE Loop 410 Floor 15 San Antonio, TX 78217		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Port Isabel Detention Center		
Physical address:	279914 Buena Vista Boulevard, Los Fresnos, TX 78566		
Mailing address: *(if different from above)*			
Telephone number:	(956) 547-1700		
Facility type:	SPC		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	OIC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(956) 547-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	SDDO
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(956) 547-[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 Port Isabel Detention Center (PIDC) (also known as the Port Isabel Service Processing Center) in Los Fresnos, Texas, was conducted July 20-21, 2021, by, U.S. Department of Justice (DOJ) and DHS certified PREA Auditors, Margaret L. Capel, Lead Auditor, and [redacted] for Creative Corrections, LLC. The Lead 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, [redacted], and Assistant ICE PREA Program Manager, [redacted], 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 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. This is the second DHS PREA audit of the facility.

The PIDC has a design capacity of 1,200 and houses male detainees exclusively. The average detainee population for the last 12 months was reported as 1,054. The average time in custody is reported as 14 days. The top three nationalities of the detainee population are Ecuadorian, Mexican, and Cuban. The facility does not house females, juveniles, or family units.

The ICE PREA audit was originally scheduled for September 22-24, 2020, and was postponed due to the COVID -health pandemic. The audit was changed to a contingency audit. ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g., a health pandemic. The process was divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. Approximately four weeks prior to the contingency audit, ERAU Team Lead, Wendy Webb, provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and Document Request, DHS Immigration Detention Facilities form, in folders for ease of auditing. All documentation, policies, and the PAQ was reviewed by the Lead Auditor and/or the second Auditor. During the Pre-Audit phase, the Auditors completed a review of submitted documentation to include the Pre-Audit Questionnaire (PAQ), facility and agency's policies, detainee detention files, investigative files, and personnel files for staff, contractors, and volunteers. The Auditors requested and reviewed eight employee personnel records, ten employee training files, eight detainee medical records, seven detainee files, and five investigation files.

The second phase, Remote Interviews, was conducted on September 29 through October 1, 2020, consisting of interviews with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers. The population on the first day of the Remote Interview phase was 220. The remote interviews were divided between the Lead Auditor and the second Auditor. The second Auditor was assigned the responsibility of interviewing detainees from targeted categories and random selection. There were 27 randomly chosen detainees interviewed. The Auditor interviewed 23 detainees with limited English proficiency (LEP), with 1 detainee that could not read, and 4 detainees who spoke English. The Auditor used Language Services Associates, provided through Creative Corrections, LLC., for interpretation assistance. There were 12 randomly selected security staff interviewed from each of the 3 shifts. Specialized interviews included the Acting Facility Administrator, the AhtnaSTS Project Manager, ICE PSA Compliance Manager, Classification Supervisor, medical staff (3), mental health staff (2), staff first responders (3), Grievance Coordinator, investigators (3), contract employees (6), Human Resource Administrator, Training Coordinator, intake staff (6), and volunteers (2). With the exception of the volunteer interviews, interviews were conducted through a conference line established between the Auditor and the facility. The Pre-audit documentation review and the Remote Interview phase was completed on October 1, 2020.

At the conclusion of the audit process, the Auditor determined the facility had 31 standards that Met, 2 standards that Exceed, 7 standards that Did Not Meet, and 1 standard that was Non-Applicable. As a result of these seven standards that did not meet compliance, the facility was placed into a corrective action period.

Standards that Did Not Meet:

§115.21 - Evidence protocols and forensic medical examinations
§115.41 - Assessment for risk of victimization and abusiveness
§115.42 - Use of assessment information
§115.53 - Detainee access to outside confidential support services
§115.67 - Agency protection against retaliation
§115.73 - Reporting to detainees
§115.86 - Sexual abuse incident reviews

The Auditor who conducted the initial audit was not available to complete the Corrective Action Plan (CAP) review; therefore, the CAP review was assigned to APM (b) (6), (b) (7)(C) for those standards found to be deficient during the facility's PREA audit. The 180-day CAP process began on October 16, 2021, with an ending date of April 16, 2022. The Agency provided the facility's initial response to the 180 Day CAP for review on December 20, 2021, which was reviewed by the APM who provided responses to the proposed corrective actions. The facility submitted additional documentation for the CAP which was reviewed by the Auditor on February 15, 2022, and March 28, 2022. After review of the submitted documentation to demonstrate compliance with the deficient standards, the APM determined compliance with five of the standards and found that two standards still did not meet based on submitted documentation or lack thereof.

This report is being completed to detail the facility's current compliance status with the previous seven deficient standards noted on the final report.

Meets Standard (5):
§115.21 - Evidence protocols and forensic medical examinations
§115.41 - Assessment for risk of victimization and abusiveness
§115.53 - Detainee access to outside confidential support services
§115.67 - Agency protection against retaliation
§115.86 - Sexual abuse incident reviews

Does Not Meet After the Corrective Action Period: (2)
§115.42 - Use of assessment information
§115.73 - Reporting to detainees

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. 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:

(e): The Auditor reviewed an MOU between the facility and the CCSO, provided by the facility. The MOU was primarily focused on providing emergency assistance in the event of an institutional emergency such as a bomb threat, escape, and staff work stoppage. The MOU does not address any PREA related services or assistance. The Auditor found the current MOU addresses institutional emergencies, i.e., escape, weather related emergencies and the like, but does not address PREA investigations or PREA related services provided by the CCSO. The PSA Compliance Manager stated he will work with the CCSO to modify the MOU to include PREA investigations conducted by the CCSO. During the on-site phase, the Auditor explained that the standard requires the facility to request the CSSO follow the requirements of paragraphs (a) through (d) but does not require a formal MOU.

Does Not Meet (e): The facility has not requested CSSO to follow the requirements of paragraphs (a) through (d) of this standard. The facility must request and provide verification that the facility has requested the CCSO to follow the requirements of sections (a)-(d) of this standard.

Corrective Action Taken (e): The facility provided a revised MOU with CCSO dated November 16, 2021, requesting the agency follow subparts (a) through (d) of this standard along with evidence that this MOU was sent to CCSO by facsimile and by email. No documentation was provided indicating that CCSO had signed the agreement; however, the facility has demonstrated full compliance with this standard through making the request.

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

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

(a)(b): PIDC Policy 4.5.13 states, "Detainees will be screened upon arrival at the facility for potential vulnerabilities to sexually aggressive behavior or tendencies to act out with sexually aggressive behavior and will be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new arrival will be kept separate from the general population until he or she is classified and may be housed accordingly. The initial classification process and initial housing assignment will be completed within 12 hours of admission to the facility." During the audit period, the Auditor interviewed 30 detainees, the majority of these detainees reported they were asked personal questions while in intake.

The Intake staff explained incoming detainees are placed in holding cells in the staging area while they are being processed into the facility, and oriented with the facility's rules and PREA. Intake staff is responsible for processing detainees into the facility. An initial custody assessment is completed during this time, after a thorough review of all available information received through the agency data base. This information may include criminal history, previous incarcerations, institutional adjustment problems, and other pertinent risk assessment information. From this information, a custody score is obtained which determines the detainee's housing assignment, but this can be adjusted dependent upon medical staff recommendations after completing the medical risk assessment. Medical staff conduct an initial evaluation which includes some PREA related questions related to risk of sexual abuse: have you been a victim of sexual abuse; are you in danger of being physically or sexually assaulted; have you received help for a developmental or learning disability; and are you transgender. Based on interviews with intake staff, the information obtained from the intake screening and the detainee's prior history review, the intake staff complete an ICE Detainee Classification System – Primary Assessment form for all incoming detainees to determine the detainee's custody score. This score largely determines a detainee's housing placement, separating those detainees with higher custody scores from those with lower scores. This score can be determined from a review of the records, prior to the detainee arriving at the facility. The Classification Supervisor stated the housing placement of detainees can be changed depending on recommendations from the medical or mental health department after completion of the medical risk assessment.

The medical risk assessment or intake documentation does not reflect the time of completion to demonstrate the assessments were completed within 12 hours. Nine of the 30 detainees interviewed reported being in intake only a couple of hours.

The Auditors reviewed 11 detainee files. Three of the detainees did not have risk assessments completed. Of the remaining eight files, all files included the custody assessment, and each were seen by medical and asked some additional questions related to the detainee's risk of victimization.

Does Not Meet (b): The medical risk assessment or intake documentation does not reflect the time of completion to demonstrate the assessments were completed within 12 hours. The initial classification process and initial housing assignments should be completed within 12 hours of admission to the facility. The facility must develop a process to ensure that the initial classification process and initial housing assignments will be completed within 12 hours of admission and can be verified for auditing purposes. The facility must provide training to staff on the revised process. The facility must provide completed assessments for 10 detainees conducted after the on-site visit to demonstrate the assessments were completed within 12 hours of arrival.

Corrective Action Taken (b): The APM reviewed the revised Detainee Classification Risk Assessment form indicating the time in and time out of processing. Completed Detainee Classification Risk Assessment forms for 8 detainees arriving after the on-site visit were reviewed indicating all were processed within 12 hours. The facility provided 8 forms instead of the 10 requested because those were the only intakes received at the time the CAP documentation was provided; this is an acceptable sample for the Auditor to determine compliance. The facility further provided training acknowledgement forms for nine employees indicating they have been trained on conducting assessments using the revised Detainee Classification Risk Assessment form. The facility has demonstrated full compliance with subpart (b) of this standard.

(c)(d): PIDC Policy 4.5.13 states, "The facility will consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. The PIDC Policy 4.5.13 also states, "The initial screening will consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to PIDC, in assessing detainees for risk of being sexually abusive. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at PIDC, the facility will consult with the FOD for additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment will not ordinarily exceed a period of thirty (30) days."

The Auditor reviewed 11 detainee files. Seven of these files either did not have a risk assessment or the risk assessment was not completed on the date of admission. Some risk factors are gathered as part of the custody assessment and entered on the ICE Detainee Classification System – Primary Assessment form. These risk factors include whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child. The completion of these two assessments completes the current PREA risk assessment for the detainee. The current risk assessment process does not ask if the detainee identifies as gay, lesbian, bisexual or is gender non-conforming; does not consider the detainee's build and appearance as a risk factor; age is noted but it is not considered as part of the risk assessment. The facility reports medical staff advises classification if, in their opinion, the detainee is at risk of sexual victimization. The risk assessment process does not consider all risk factors in total to determine if the detainee is at risk of victimization or abusiveness. The sharing of this information is imperative to making an individualized assessment of detainees' risk of abusiveness or victimization. Intake staff interviewed explained that ICE provides information to the facility, as it is known to ICE, regarding a detainee's criminal history, prior institutional violence, or sexual abuse.

Does Not Meet (c)(d): The current procedures for assessing a detainee's risk of victimization or abusiveness does not address each of the requirements of the standard. Some questions are asked by intake staff and some questions asked by medical staff. This information is not routinely shared. The facility should revise the risk assessment to ensure all required criteria for risk of victimization are addressed and the determination for risk of victimization is shared with effected parties. The facility must develop a process to capture all the required information to meet the standard requirements in order to assess detainees on intake to identify those likely to sexual aggressors or sexual abuse victims. All required information must be considered during this risk assessment. The facility must provide the process developed to capture all the required information and how the information will be utilized to complete the initial classification and housing assignment as well as documented staff training on the process for compliance review. The facility also must provide 10 examples conducted after the on-site visit to the Auditor to demonstrate compliance.

Corrective Action Taken (c)(d): The APM reviewed the revised Detainee Classification Risk Assessment form and found that all requirements of this standard are now included for consideration on the form. The APM also reviewed eight Detainee Classification Risk Assessment forms completed after the on-site visit using the revised form. The facility further provided training acknowledgement forms for nine employees indicating they have been trained on conducting assessments using the revised Detainee Classification Risk Assessment form. The facility has demonstrated full compliance with subparts (c) and (d) of this standard.

(e) PIDC Policy 4.5.13 states, "PIDC will reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information, or following an incident of abuse or victimization." The Auditors reviewed 11 detainee files and found reassessments were completed for only four of the detainees. The reassessment form provided was a custody reassessment but did not assess the detainee's risk of abusiveness or victimization. These factors are considered on the medical risk assessment which was not provided. Furthermore, per the Performance-Based National Detention Standards 2011, which PIDC is obligated to comply with, reassessments of the victim and abuser after an incident of sexual abuse are required to be completed within 24 hours; however, they were not completed within the required timeframe.

Does Not Meet (e): A reassessment of a detainee's risk of victimization and abusiveness must be completed within 60-90 days of admission. A reassessment of the victim and abuser must also be completed within 24 hours of the allegation per PBNDS 2011. If the investigation determines the allegations were unfounded, another reassessment may be warranted for the victim and/or abuser, due to receiving additional information based on the results of the investigation. The facility must provide 10 examples conducted after the on-site visit of detainee's risk of victimization and abusiveness being re-assessed within 60-90 days of admission. Additionally, if there is an incident of risk or victimization during the CAP period, the facility must provide reassessments completed for those detainees within the required timeframe.

Corrective Action Taken (e): The APM reviewed the revised Detainee Classification Risk Assessment form and found a section has been added to the form for the assessor to select the type of review (60-Day Review or a 90-Day Review) and to enter a date of the review. On February 15, 2022, the APM reviewed 6 detainee Classification Risk Assessments that were completed for the 60-day review. There were no reassessments conducted after an incident of sexual abuse within the CAP period to provide the Auditor for review; there was one allegation reported within the period, but the detainee was released two days after making the allegation at which time a reassessment had not been completed. Based on the APM's review of the investigative summary, this case was unfounded, therefore no reassessment was required to be completed on the alleged aggressor. Based on new guidance from ERO, the 24-hour requirement in the PBNDS-2011 does not apply to the reassessment required following an incident of abuse or victimization. Based on this new guidance and previous misinterpretation, this provision is no longer a deficiency. The APM's consideration of the documentation provided during the CAP period finds the facility has demonstrated compliance with subpart (e) of this standard.

Based on review of the documentation presented by the facility during the corrective action period, the facility has demonstrated compliance with all subparts of this standard.

§115. 42 - Use of assessment information
Outcome: Does not Meet Standard
Notes:

(a): As noted in 115.41 above, intake staff explained that ICE provides information to the facility, as it is known to ICE, regarding a detainee's criminal history, prior institutional violence, or sexual abuse. The intake staff complete a Detainee Classification System – Primary Assessment form to determine the detainee's custody score. This score largely determines a detainee's housing placement, separating those detainees with higher custody scores from those with lower scores. This score is determined from a review of the records, prior to the detainee arriving at the facility. The Classification Supervisor and intake staff stated the housing placement of detainees can be changed depending on recommendations from the medical or mental health department after completion of the medical risk assessment. The facility makes housing placements, recreation, other activities, and voluntary work based on the custody scores and medical recommendations, if any. During the on-site visit, the Auditors reviewed the facility's process for gathering information about a detainee's PREA risk factors when making initial housing assignments. Although medical and/or mental health staff advise classification staff if they determine a detainee is at risk of victimization, all risk factors are not taken into consideration when making housing and program placement decisions.

Does Not Meet (a): The facility does not have a formal risk assessment process and does not consider all required risk factors when making housing and program assignments. The current risk assessment process does not ask if the detainee identifies as gay, lesbian, bisexual or is gender non-conforming; the detainees build and appearance; age is noted as a risk factor on the intake risk assessment or medical risk assessment but is not considered as part of the risk assessment. The facility reports medical staff advises classification if, in their opinion, the detainee is at risk of sexual victimization. The risk

assessment process does not consider all risk factors in total to determine if the detainee is at risk of victimization or abusiveness. The sharing of this information is imperative to making an individualized assessment of detainees' risk of abusiveness or victimization. The facility must develop a process to capture all the required information to meet the standard requirements in order to assess detainees on intake to identify those likely to sexual aggressors or sexual abuse victims. All required information must be considered during this risk assessment. The facility must provide the process developed to capture all the required information and how the information will be utilized to complete the initial classification and housing assignment as well as documented staff training on the process for compliance review, as recreation and other programs are largely determined by the detainee's classification and housing assignment. The facility also must provide 10 examples over a time period established by the Auditor to demonstrate compliance.

Corrective Action Taken (a): The APM reviewed seven examples of the assessment form processed after the 115.42 procedures were updated in the policy for compliance and found that the form includes all information required to assess detainees for their risk to be sexual aggressors or sexual abuse victims. The facility also provided training records for staff who conduct intake processing which were reviewed by the Auditor. The facility policy PIDC 4.2.2, Classification, has been updated to include a procedure of notification to identified parties for the purpose of housing, recreation, voluntary work, and other activities of detainees who are determined to be "at risk" for sexual victimization or abusiveness from the Detainee Risk Assessment Form. However, the APM requested ten examples to demonstrate compliance and these examples were not provided. Examples must include detainees who were assessed using the revised Detainee Risk Assessment Form (see 115.41). The facility has not provided the Auditor with the process of how collection of this information informs housing, recreation and other activities, and voluntary work assignment decisions. The instructions on the form state "Detainee will be appropriately classified and housed.", but that does not explain the process. The APM requested explanation of how the facility made decisions using the information from the assessments for ten detainees (10 detainees provided for 115.41) to demonstrate compliance; the risk assessments were provided but no explanation how the information was used to inform housing, recreation and other activities, and voluntary work assignment decisions. Examples must include detainees who were assessed using the revised Detainee Risk Assessment Form (see 115.41). This standard remains non-compliant.

§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:

(c)(d): The facility also provided a copy of a posting in the detainee housing area titled Sexual Assault Victim Service Providers. The posting provides the name of the community organization, phone number, hotline number, and website. The posting does not address confidentiality. The facility provided a copy of excerpts from the detainee handbook which states detainees can report sexual abuse to an outside organization, but it does not address whether these calls are confidential. Of the 30 detainees interviewed during the audit, 13 detainees did not know of these organizations. The remaining detainees were aware of the community organizations but were unsure what services these organizations provide. The Auditor reviewed six investigations during the audit period and found only one instance in which an alleged victim was provided information (pamphlet) about the community organizations.

Does Not Meet (d): The facility must inform detainees prior to giving them access to outside resources, of the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws and must provide information to alleged victims about these community organizations. The facility must develop a process to inform detainees prior to giving them access to outside resources, of the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws and must provide information to alleged victims about these community organizations and provide this information to the detainee population. Staff training must be conducted on the process. The facility must provide the process, documentation on how detainees are informed, and the documented staff training for compliance review.

Corrective Action Taken (d): Based on the APM's review of the information provided, the facility has three victim advocates (Friendship of Women, Inc., Family Crisis Center, Inc., and Women Together/Mujeres Unidas,) who will provide crisis service to victims as well as being present during law enforcement interviews and forensic examinations. The Port Isabel Detention Center Detainee Handbook Local Supplement informs detainees that "outside agencies may forward any reports of abuse to the facility and authorities in accordance with mandatory reporting laws." The APM reviewed a sample of seven Detainee Summary Forms indicating detainees received the detainee handbook. The APM reviewed a sample of 10 staff training signed acknowledgements stating, "the employee understands the importance of informing the detainee of the available Community Resources, as outlined in the DHE/ICE-ERO "Detainee Handbook" and, as posted throughout the facility." The facility has demonstrated compliance with all subparts of this standard.

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

Notes:

(a)(b)(c): PIDC Policy 4.5.13 requires employees, contract staff and volunteers to receive initial and annual SAAPI training. This training includes the right of detainees and staff to be free from sexual abuse and agency prohibitions on retaliation against detainees and staff who report sexual abuse and PIDC will employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainee or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations.

PIDC Policy 4.5.13 states, "PIDC will employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainee or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. For at least 90 days following a report of sexual abuse or assault, PIDC will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and will act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments by staff. The facility will continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need."

The facility provided a memorandum from the AFOD stating there have been no reports of detainee or staff retaliation related to sexual abuse/assault incidents in the audit period. The Acting Facility Administrator stated it is important for staff responsible for retaliation monitoring to maintain an open line of communication with detainees and to monitor any program changes or incident reports. She also stated when monitoring staff for retaliation an open line of communication must be maintained with the staff member and absences, negative performance reviews, and post assignment changes should be monitored. The PSA Compliance Manager stated detainees would be monitored for retaliation for as long as they are in the facility. The AhtnaSTS Project Manager stated the facility Captains monitor for retaliation, but he was unclear if the retaliation monitoring was documented. The ICE PSA Compliance Manager indicated the facility would monitor both staff and detainees for any retaliation, including monitoring for as long as the detainee is at the facility. There were no detainee victims at the facility during the interview phase of the audit.

The Auditors reviewed five investigations during the pre-audit phase and one investigation during the on-site phase. There was no record of retaliation monitoring for any six investigations reviewed. The Auditor verified one alleged victim was released two days after making the sexual abuse allegation, so there was no record of retaliation monitoring. The facility could not verify retaliation monitoring occurred for any of the six alleged victims (or witnesses when applicable).

Does Not Meet (c): Retaliation monitoring could not be verified for any of the alleged victims. The facility must be able to demonstrate alleged victims (and witnesses when applicable) are monitored for retaliation immediately following an allegation of sexual abuse. The facility must develop a process to ensure retaliation is initiated and monitored for at least 90 days following an allegation of sexual abuse. The facility must provide training to staff responsible for monitoring retaliation. The facility must provide the process, documented staff training, and five examples of retaliation monitoring, if available.

Corrective Action Taken (c): The APM reviewed the documentation provided and the facility explained that there was one allegation reported on 01/06/2021 by a detainee who was released on 01/08/2021 which did not allow the facility adequate time to have any report of retaliation monitoring documented. The facility advised in their CAP form that there have been no new allegations during the CAP period, which is why the 2021 case is being used to determine compliance. The facility has developed a process to ensure that retaliation monitoring will occur on any future allegations reported. Their process includes creation of a "Retaliation Monitoring Sheet" that will be used during the initial victim interview and will be completed every 30 days for at least 90 days to ensure that the alleged victim is not being retaliated against. Once completed, the monitoring sheet is to be placed into the PREA case file. The facility has designated a PREA investigator, employed by the contractor AhtnaSTS, who is to monitor retaliation and periodically interview the non-citizen to ensure there is no retaliation taking place. The facility provided a sample of 10 staff PREA Training Certification forms where staff received refresher training that included right of detainees and staff to be free from retaliation for reporting sexual abuse. The facility has demonstrated compliance with all subparts of this standard.

§115. 73 - Reporting to detainees
Outcome: Does not Meet Standard
Notes:

The Facility Administrator confirmed that detainees are notified of the results of the investigation. The PSA Compliance Manager explained that ICE notifies the detainees of the results of the investigation and the facility is provided a copy of the notification. He explained that detainees usually are at the facility for only 15-20 days. If the detainee provided a forwarding address, the notification would be sent to the detainee. Copies of the notifications are maintained in the facility's investigation files, as observed by the Lead Auditor during file reviews. There were six investigations reviewed during the

audit period. One investigation was open, and one allegation was not reported to JIC, so the agency did not close the investigation for the unreported case and notify the detainee of the results of the investigation. Of the remaining four investigations, one detainee was provided notification of the results of the investigation. Two investigation files included a copy of the Notification from ICE, but the form was unsigned by detainee or staff and the Auditor was unable to confirm if the detainee victim was provided with notification of the results of the investigation or the reason for which the detainee was unable to be notified. One detainee was told the abuser was issued a disciplinary infraction and housed in SMU, but he was not notified the allegation was substantiated.

Does Not Meet: The agency/facility did not provide consistent notification to the alleged victim of the outcome of the investigation. The agency/facility must ensure every effort is made to notify the alleged victims of the results of the investigation while they are still in immigration custody, or when otherwise feasible. The agency must develop a process to ensure notifications are provided to all detainees of the result of the investigation and any responsive action taken. Agency staff responsible for making notifications must be trained on the process. The agency must provide the process, documented staff training, and two examples of notifications made to a detainee for compliance review.

Corrective Action Taken: The APM reviewed email correspondence advising the DFOD of the results of the investigation in accordance with policy PIDC 4.5.13. The APM requested the agency explain what efforts have been employed to ensure that following an investigation into a detainee's allegation of sexual abuse, notification will be made to the detainee as to the results of the investigation and any responsive action taken. No additional documentation was provided to the APM to demonstrate employment of a procedure to ensure that following an investigation into a detainee's allegation of sexual abuse, notification will be made to the detainee as to the results of the investigation and any responsive action taken. This standard remains non-compliant.

§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): PIDC Policy 4.5.13 states, "PIDC will conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For any substantiated or unsubstantiated allegation, the facility will 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 and assault. PIDC will implement recommendations for improvement or document its reasons for not doing so in a written response. Both the report and response will be forwarded to the FOD, or his or her designee, for transmission to the PSA Compliance Manager. The facility will also provide any further information regarding such incident reviews as requested by the PSA Compliance Manager."

The Auditors reviewed six investigations during the audit period, five closed and one open. Sexual abuse incident review boards reviewed the four of the five closed investigations. There were no dates provided on the sexual abuse incident reports for the Auditor to confirm the reviews were conducted within 30 days of the conclusion of the investigation. The facility explained the dates of the Sexual Incident Reviews are in the facility's data base. The Auditor asked the facility to check the dates of the reviews and provide the information to the Auditor. The Auditor did not receive these dates.

Does Not Meet (a): The facility could not provide documentation that the sexual abuse incident reviews were completed within 30 days from the conclusion of the investigation. The facility must develop a method to capture the time frame of the review to ensure the review is completed within 30 days from the conclusion of the investigation. Staff must be trained on the timeframe requirement. The facility must provide the process to capture the incident review completion date, documented staff training, along with two examples of incident reviews completed in a timely manner for compliance review.

Corrective Action Taken (a): The facility provided a completed sexual abuse incident review conducted on 3/22/2022, of the case from 2021 that had not been reviewed at the time of the audit, which indicated review panel members were from IHSC, ICE, and AhtnaSTS. The facility advised in their CAP form that there have been no new allegations during the CAP period, which is why the 2021 case is being used to determine compliance. The facility has developed a process to ensure that retaliation monitoring will occur on any future allegations reported. The sign-in sheet and a memo to file documenting the review were also presented for the APM's review. The facility has demonstrated compliance with subpart (a) of this standard.

(c) PIDC Policy 4.15.13 states, "PIDC will conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility will prepare a negative report. The results and findings of the annual review will be provided to the OIC, AOIC or AFOD and FOD, or his or her designee, for transmission

to the ICE PSA Coordinator." During the on-site visit, the annual review of sexual incident investigations was not provided, nor provided after the audit as requested for review.

Does Not Meet (c): The facility was unable to provide an annual review of any sexual abuse investigation. The facility must complete an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse investigation, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility should prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, Field Office Director (FOD) or his or her designee and the agency PSA Coordinator. An annual review for all investigations should be conducted and submitted for compliance review.

Corrective Action Taken (c): The APM was provided the annual review for sexual abuse allegations for 2021 on February 15, 2022, which addressed response efforts of substantiated investigations. On March 28, 2022, the facility provided an updated annual review that included all allegations reported within the audit period as required. The facility has demonstrated compliance with subpart (c).

Based on review of the documentation presented by the facility during the corrective action period, the facility has demonstrated compliance with all subparts of this standard.

AUDITOR CERTIFICATION:

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

Sharon R. Shaver May 17, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) May 17, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(E) May 17, 2022
Program Manager's Signature & Date