PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Joseph Z. Martin	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	270 625 (b) (6), (b)

AGENCY INFORMATION	
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)

FIELD OFFICE INFORMATION	
Name of Field Office:	San Antonio Field Office
Field Office Director:	Daniel Bible
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	
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:	27991 Buena Vista Road		
Mailing address: *(if different from above)*			
Telephone number:	956-547-(b) (6), (b)		
Facility type:	SPC		
Facility Leadership			
Name of Official/Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge (OIC)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	956-547-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer (SDDO)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	956-547-(b) (6), (b)

AUDIT FINDINGS

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) on-site audit of the Port Isabel Detention Center (PIDC) in Los Fresnos, Texas was conducted on March 13-15, 2018, by Joseph Z. Martin and (b) (6), (b) (7)(C) PREA Auditors contracted through Creative Corrections, LLC. This will be the first PREA audit for the facility. The Port Isabel Detention Center is a Processing Center that holds male and female detainees of the U.S. Immigration and Customs Enforcement (ICE), whose immigration status or citizenship has not been officially determined or who are awaiting repatriation. It is operated by Ahtna Technical Services, Incorporated. The purpose of the audit was to determine compliance with The Department of Homeland Security (DHS) PREA standards.

The point of contact established for PIDC was through the External Reviews and Analysis Unit (ERAU) Team Lead (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) provided the completed Pre-Audit Questionnaire (PAQ) along with supporting documentation by placing it in the facilities folder on the DHS ERAU webpage approximately 2 weeks prior to the on-site portion of the audit. Pre-audit preparation by the Auditors included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed PAQ. The documentation reviewed included agency policies with corresponding attachments, procedures, forms, training records and curriculum, facility layout and other PREA related materials that were provided to demonstrate compliance with the PREA standards. The documentation submitted, to include the questionnaire, was very complete and informative.

An entry-briefing, led by the ERAU Team Lead (b) (6), (b) (7)(C) was conducted shortly after arrival at the facility on the first day of the on-site review. In attendance were:

(b) (6), (b) (7)(C)	ICE Team Leader, External Reviews and Analysis Unit (ERAU)
(b) (6), (b) (7)(C)	ICE ERAU Section Chief,
(b) (6), (b) (7)(C)	CEO, Creative Corrections/Contractor
(b) (6), (b) (7)(C)	Auditor, Creative Corrections/Contractor
(b) (6), (b) (7)(C)	Auditor, Creative Corrections/Contractor
(b) (6), (b) (7)(C)	ICE Deportation Officer (DO)
(b) (6), (b) (7)(C)	Contracting Officer Representative (COR)
(b) (6), (b) (7)(C)	Physical Security Inspector (PSI)
(b) (6), (b) (7)(C)	Health Service Administrator (HSA)
(b) (6), (b) (7)(C)	Assistant Health Service Administrator (AHSA)
(b) (6), (b) (7)(C)	SDDO, Prevention of Sexual Assault (PSA) Compliance Manager
(b) (6), (b) (7)(C)	Assistant Officer in Charge (AOIC)
(b) (6), (b) (7)(C)	Quality Control (QC)
(b) (6), (b) (7)(C)	QC
(b) (6), (b) (7)(C)	ICE DO
(b) (6), (b) (7)(C)	ICE DO
(b) (6), (b) (7)(C)	Quality Assurance (QA)
(b) (6), (b) (7)(C)	QC
(b) (6), (b) (7)(C)	OIC
(b) (6), (b) (7)(C)	Assistant Officer in Charge (AOIC)

Immediately following the entry-briefing, PSA Compliance Manager (b) (6), (b) (7)(C) and Team Lead (b) (6), (b) (7)(C) lead the Auditors and facility staff on a tour of the facility. The tour covered all areas of the facility including Staging Area, Processing/Intake, Medical, Kitchen, Special Management Unit, Laundry, Barber Shop, Chapel, Alpha housing unit, Bravo housing unit, Charlie housing unit, Delta housing unit, Holding cells, and Central Control. The facility has 526 employees, of which 454 are security staff and 72 are medical and mental health staff. There are no medical staff trained to conduct forensic medical examinations. The facility has seven buildings to include multiple occupancy housing units, single occupancy cell housing units, segregation cells used for administrative and disciplinary purposes, medical infirmary beds, and mental health unit beds. The design capacity for the facility is 1200 with the average population being 1063, 960 male with 103 female. The average time in custody is 15 days.

During the tour the Auditors made note of PREA information to include reporting mechanisms posted throughout the facility, cross-gender announcements being made each and every time before entering housing units, unannounced rounds being documented, separation of male and female detainees and the high number and (b) (7)(E) The Auditors also spoke informally to staff and detainees throughout the tour. The facility has 408 cameras and is always looking and considering to add more. It was also noted that audit notices were posted in each housing unit. The Auditors received no PREA correspondence from anyone at the facility.

After the tour, the Auditors started the interview process of staff and detainees. Interviews were held in private settings that held the responsibility of confidentiality while also allowing security observation. Interviews included random selections for staff and detainees as well as specialized staff interviews and targeted detainee interviews. Detainee interviews consisted of a good balance of male and female using interpretation services from Language Services and Associates. A total of 28 staff were interviewed that included 12 Security Staff, including Line Staff and First-Line Supervisors (from all shifts and different posts), 3 Medical/Mental Health, 1 OIC, 1 PSA Compliance Manager, 2 Non-Security Staff First Responders, 2 Intake Staff, 1 Administrative Human Resources, 1 Classification Supervisor, 2 Training Supervisors, 1 Grievance Coordinator, 1 Chaplain, and 1 Volunteer. Detainee interviews consisted of 15 random of male and female with different languages and 15 targeted that included 12 Limited English Proficient (LEP) – (Spanish, Chinese) and 3 Disabled. PIDC reported 0 incidents of sexual abuse within the last 12 months but within the last 3 years 2 incidents have been reported. The first from 10/26/2015 which was found to be unsubstantiated and the second from 3/1/2016 that was also found to be unsubstantiated.

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.

On Thursday March 15, 2018 an exit-briefing was conducted at approximately 4:10 p.m. local time. The exit-briefing was opened by ERAU Team Lead (b) (6), (b) (7)(C) and then turned over to the Auditors for an overview of the on-site findings and a close-out summary. Those in attendance for the exit-briefing were:

(b) (6), (b) (7)(C)	ICE Team Leader ERAU
(b) (6), (b) (7)(C)	ICE ERAU Section Chief,
(b) (6), (b) (7)(C)	Auditor, Creative Corrections/Contractor
(b) (6), (b) (7)(C)	Auditor, Creative Corrections/Contractor
(b) (6), (b) (7)(C)	ICE DO
(b) (6), (b) (7)(C)	COR
(b) (6), (b) (7)(C)	PSI
(b) (6), (b) (7)(C)	HSA
(b) (6), (b) (7)(C)	AHSA
(b) (6), (b) (7)(C)	SDDO, PSA Compliance Manager
(b) (6), (b) (7)(C)	AOIC
(b) (6), (b) (7)(C)	PIDC QC
(b) (6), (b) (7)(C)	PIDC QC
(b) (6), (b) (7)(C)	ICE DO
(b) (6), (b) (7)(C)	ICE DO
(b) (6), (b) (7)(C)	PIDC QA
(b) (6), (b) (7)(C)	PIDC QC
(b) (6), (b) (7)(C)	PIDC OIC
(b) (6), (b) (7)(C)	PIDC AOIC

During the exit-briefing the Auditors discussed observations of the on-site review. The Auditors observed staff having a good rapport with the detainees, good interaction was observed with a heavy presence of security throughout the facility with a high number of video monitoring placed throughout the facility. In addition, the facility had excellent sanitary conditions including the housing units and kitchen areas. The Auditors also observed how PIDC's compliance team had great care in PREA compliance and helped with any questions or additional documentation needs.

The Auditors found that PIDC exceeded 2 standards, met compliance on 32, non-applicable on 1 and 6 were found to be non-compliant.

Standards found to exceed compliance:

Training and Education 115.31 and 115.32

Standards found to meet compliance:

Prevention Planning 115.11, 115.13, 115.15, 115.16, 115.17, 115.18,
Responsive Planning 115.22
Training and Education 115.33, 115.34, 115.35
Screening for Risk of Sexual Victimization and Abusiveness 115.42 and 115.43
Reporting 115.51, 115.52, 115.53, 115.54,
Response 115.61, 115.62, 115.63, 115.64, 115.65, 115.66, 115.68,
Investigations 115.71, 115.72
Discipline 115.77, 115.78
Medical and Mental Care 115.81, 115.82, 115.83,
Data Collection and Review 115.87
Scope of Audits 115.201

Standards found to be non-compliant:

Responsive Planning 115.21
Screening for Risk of Sexual Victimization and Abusiveness 115.41
Response 115.67
Investigations 115.73
Discipline 115.76
Data Collection and Review 115.86.

Standard found to be non-applicable: Juvenile and Family detainees 115.14

Each standard below gives the Auditors determinations to include any recommendations that were made.

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	2
Number of standards met:	32
Number of standards not met:	6
Number of standards N/A:	1

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. If additional space for notes is needed, please utilize space provided on the last page.

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

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

Notes:

(c) PIDC policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention mandates zero tolerance towards all forms of sexual abuse and outlines the facilities approach to preventing, detecting, and responding to such conduct.
(d) PIDC has a designated Prevention of Sexual Assault Compliance Manager. The organization chart provided by PIDC supports this designation and he reports directly to the OIC. The PSA answered through interviews that he has sufficient time to carry out his duties as PSA.

§115.13 – Detainee supervision and monitoring.

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

Notes:

(a)PIDC ensures sufficient supervision of detainees by providing adequate staffing levels on all three shifts. Annual Reviews of staffing levels are performed and video monitoring is used to protect detainees. Auditors reviewed various staffing rosters, post orders, and the layout of video monitoring to ensure sufficient supervision was provided. Interviews of the OIC and PSA corroborated that sufficient numbers of staff are on duty for all three shifts which include mandatory posts.
(b) PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention and Unit Pod Officer Post Orders give direct specific guidelines to ensure detainee supervision is given. A review of those guidelines indicated they had been reviewed in the past year, also, OIC and PSA interviews corroborated these guidelines are reviewed at least annually.
(c) Interviews of the OIC and PSA along with answers on the Pre-Audit Questionnaire indicate the facility considers 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, the findings and recommendations of sexual abuse incident review reports and any other relevant factors, including but not limited to the length of time detainees spend in agency custody when determining adequate levels of detainee supervision and determining the need for video monitoring.
(d) PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention and PIDC 3.1.18 Searches, direct that unannounced rounds are to be performed. Interviews of random staff corroborated this practice as well as documentation reviewed indicated they occurred on different shifts.

§115.14 – Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

PIDC does not house Juvenile or family detainees.

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

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

Notes:

(b) PIDC's PAQ states that female staff only perform pat-down searches of male detainees when male staff is not available or exigent circumstances arise. Interviews of random security staff corroborates this practice and indicated while they do occur female staff know they are only to perform if male staff are not available or in the case of an exigent circumstance. PIDC reported 1 instance of this occurring in the last 12 months and it was due to no male staff being available.
It is recommended that PIDC develop a log specific to searches to include pat-down searches.
(c) PIDC 3.1.18 Searches, directs that staff of the same gender will perform searches. Staff Interviews indicated that cross gender pat down searches of female detainees are not performed minus exigent circumstances.
(d) PIDC reported 1 incident in the last 12 months and documentation was produced of where it was logged. PIDC 3.1.18 Searches, directs that searches are to be performed by staff of the same gender as the detainee except in exigent circumstance.
It is recommended that PIDC 3.1.18 be revised to specifically state that all cross-gender searches shall be logged.
(e) PIDC 3.1.18 directs that staff of the same gender shall perform cross-gender strip and cross-gender visual body cavity searches minus exigent circumstances. Staff interviews corroborated this practice. PIDC reports no occurrences in the last 12 months.
(f) PIDC 3.1.18 directs that strip searches and body cavity searches shall be documented. The PIDC PAQ confirms that all strip searches and visual body cavity searches shall be documented. PIDC reports no occurrences in the last 12 months.
(g) PIDC 4.5.13 Sexual Abuse and Assault Prevention and Intervention directs staff of the opposite gender are required to announce their presence when entering a housing unit. PIDC policy 4.4.1 Detainee Hygiene directs that detainees shall be able to shower, perform bodily functions and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when incidental due to routine cell checks. During the tour it was noted that signs are posted to remind staff of this standard and practice observed corroborated. During the tour it was found that the male detainee housing unit wings did not provide sufficient privacy for showering in the case that female staff come into the unit. Through staff interviews it was determined that females do go into these areas and may potentially see detainee's showering while performing rounds. This issue was discussed with PIDC staff and it was discussed to consider adding privacy partitions in front of the open shower walkway or to revise post orders and/or policy to prohibit females from entering the units. On April 9, 2018 documentation was sent to the Auditors of where Port Isabel has added privacy partitions to these areas. These additions provide adequate privacy for detainees while showering.
(h) N/A this facility is not a Family Residential Facility.
(i) Interviews of PIDC staff including medical and security staff indicated that detainees are not searched for the sole purpose of determining detainee's genital characteristics. The Auditors reviewed applicable training curriculum which also prohibits searching for the sole purpose of determining the detainee's genital status. PIDC's PAQ supports this as well.
(j) PIDC reports they currently have no transgender or intersex detainees. The Auditors reviewed training curriculum used which was identified as training provided by the PREA Resource Center and provides specific instruction and demonstrates how to conduct cross-gender searches and searches of transgender and intersex detainees. Staff interviews corroborated they have received this training and demonstrated knowledge. Documentation was reviewed of acknowledgment forms of such training.

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

(a ,b) PIDC 5.1.13 Disabled and LEP detainees, directs the sections of this standard to ensure that detainees who are limited English proficient (LEP), have a disability or who are blind, deaf or illiterate have an equal opportunity to benefit and participate in all the agency and facility efforts to prevent, detect, and respond to sexual abuse. Staff interviews indicated that staff would read the sexual abuse orientation program to detainees who are blind, have sign language interpreters for detainees who are deaf, have Medical and Mental Health staff communicate with detainees who have intellectual, psychiatric or have speech disabilities and have audio available for detainees who have limited reading skills. Detainee interviews corroborated this policy and practice of the facility. Detainee handbooks are provided in the language that the detainee feels most comfortable understanding. Interpretive services are available when needed
(c) PIDC uses ERO Language Services (ELS) which is an Interpretive service that is used when needed as well as having many staff who are bilingual that speak English and Spanish. Reporting Mechanisms and avenues are posted in all housing units in English and Spanish and this key information is contained in the Detainee Handbook. Staff interviews corroborate that they had knowledge of using appropriate other detainees as an interpreter as well as who not to use.

§115.17 – Hiring and promotion decisions.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a,b,c,d)U.S. Immigration and Customs Enforcement (ICE) has an agency protocol that background investigations (e-QIP) are conducted for all staff that includes volunteers and contractors. This background investigation includes the components from this section. Documentation reviewed consisted of a current employee who was promoted and a contractor who also had the background investigation completed. During the on-site review auditors reviewed three random samples of current ICE staff and three random samples of contract staff to ensure they are consistent with having the five-year background investigation. Documentation was provided by the facility to confirm the three contract staff had received background checks within the past five years. However, for the ICE employees no documentation or files were on-site to be reviewed to check for 5-year background checks. Unit Chief- (b) (6), (b) (7)(C) of the ICE Personnel Security Unit was contacted and provided documentation that three selected ICE staff had their five-year updated background investigation within the correct timeline.
(e) This component is clearly outlined on the submission of the background investigation that omissions or providing false information shall be grounds for termination or a withdrawal of the offer of employment. The PIDC PAQ corroborates this as well.
(f) The Human Resources staff interview confirmed this practice as well as the PAQ.

§115.18 – Upgrades to facilities and technologies.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a, b) PIDC 2.2.1 Facility Designs supports both sections of this standard as it requires consideration on the effect of the design, acquisition, expansion, or modification upon their ability to protect detainees from sexual abuse. PIDC currently has 408 cameras which provides coverage throughout the facility to include blind spots and high traffic areas. Central Control staff continually monitor cameras throughout the facility. The facility indicates no expansions or modifications have been made since 2014 however, facility staff did indicate that video monitoring has been added since 2014 and that they are always considering periodic updates to the video monitoring system. It was evident through PSA and OIC interviews that consideration was given to the effect of how these upgrades would protect detainees from sexual abuse.

§115.21 – Evidence protocols and forensic medical examinations.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a) IHSC 11738.3 Sexual or Physical Assault, Abuse and/or Neglect provides protocol that maximizes the potential for obtaining usable physical evidence for investigations. This policy was written in conjunction with the DHS. PIDC does not house juveniles.
(b) PIDC provides 3 different victim advocate services. They are Friendship of Women, Family Crisis Center and Women Together/Mujeres Unidas. PIDC 11738.3 states that Mental Health staff initiate outside services for victims of sexual abuse or sexual assault when indicated. PSA corroborated these services are readily available and information pertaining to them is posted.
(c) IHSC 11738.3 states that forensic examinations will be provided to detainee victims at no cost to the detainee. Medical Staff interviews corroborated that detainee victims would have access to forensic examinations and if a SAFE or SANE were to not be available, other qualified health care staff would perform the exam. Valley Baptist hospital provides access to Sexual Assault Nurse Examiners staff. The PSA provided this information.
(d) PIDC offers victim services from three community-based organizations and posts their contact information in the Detainee Handbook. They are Friendship of Women, Inc., Family Crisis Center and the Women Together/Mujeres Unidas Center. The Auditors contacted the Friendship of Women, Inc. who confirmed they provide victim advocate services to PIDC to include support during forensic exams and investigatory interview.
(e) During the on-site audit it was found that PIDC has not requested the local law enforcement to follow the requirements of sections (a, b, c, d) of this standard which direct for following a uniform evidence protocol for obtaining usable physical evidence for Administrative and Criminal investigations, utilizing available community resources and services providing crisis intervention and counseling, and for alleged detainee victims to undergo Forensic Examinations with the detainee's consent. On April 9, 2018 the Auditors received documentation that a Memorandum of Understanding had been developed between ICE, Enforcement and Removal Operations (ERO), San Antonio Field Office (SNA), PIDC, and the Cameron County Sheriff's Office. Although the memorandum of understanding (MOU) mentions the inclusion of a rape crisis center SAFE/SANE's, it does not request the outside investigative entity (Cameron County Sheriff's Office) follow the requirements of sections a-d as required in section e. Therefore, this section of the standard is non-compliant. For compliance, a recommendation would be for the facility to submit a separate request to follow all of the components of section 115.21 to the Cameron County Sheriff's Office.

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

(a)Sexual Abuse and Assault Prevention and Intervention (SAAPI) (ICE Policy 11062.2) establishes an agency protocol to ensure that each allegation of sexual abuse is investigated and referred to the appropriate investigative authority to include the Cameron County Sheriff's office when allegations appear to be criminal. PIDC 4.5.13 Sexual abuse and Assault Prevention and Intervention is the facility's policy that includes protocol to ensure all allegations of sexual abuse are investigated. All allegations of sexual abuse are reported to Field Office Director (FOD), the Office of Inspector General (OIG) and the Office of Professional Responsibility (OPR). The ICE OPR has oversight responsibilities to ensure all components of the investigative process have been conducted, as well as coordinating all efforts with federal, state, or local law enforcement or facility incident review personnel.
(b) ICE policy 11062.2 gives specific information on the agency and facility responsibility and to contact local law enforcement when applicable. PIDC 4.5.13 directs that all sexual abuse investigations be maintained for 7 years.
(c) ICE posts its protocol on its website with access to ICE Policy 11062.2. PIDC Policy 4.5.13 is available to the public by viewing online at the Code of Federal Regulations.
(d, e, f) The protocol ensures all proper notifications and referrals. The Auditors reviewed the two investigations which indicated that the allegations were referred to Joint Intake Center (JIC), OPR and the Cameron County Sheriff's Office.

§115.31 – Staff training.
Outcome: Exceeds Standard (substantially exceeds requirement of standard)
Notes:

(a, b) ICE policy 11062.2 requires training in each component of section a (1-9) for all ICE personnel who may have contact with individuals in ICE custody, including all ERO officers and Homeland Security Investigations (HSI) special agents. Auditor interviews of ICE staff and full-time contract staff verified this training is taught initially for new-hires and annually for in-service. Auditors reviewed the training curriculum used and all components of section a(1-9) are met. All staff to include ICE and full-time contract staff receive annual training which exceeds the requirement of the standard to provide refresher information every two years.
(c) Auditors reviewed documentation of sign-in sheets and certificates of this training. Sign-in sheets and certificates of training completion for one staff from all three shifts were reviewed.

§115.32 – Other training.
Outcome: Exceeds Standard (substantially exceeds requirement of standard)
Notes:

(a, b) The training curriculum was reviewed and covers the required components of these sections that are to be taught. A random selected volunteer was interviewed and verified they had received the training.
(c) The Auditors reviewed documentation of a class sign-in sheet and 3 random samples of acknowledgment forms signed by volunteers.
All PIDC volunteers, including the religious service volunteers and other contractors providing services on a non-recurring basis at PIDC receive annual training which exceeds 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:

(a, b) PIDC 4.5.13 states that all detainees are to receive education of the subjects outlined in section (a). This policy also states the OIC or AOIC shall ensure this education is given. The two Intake staff interviewed confirmed this training is provided and done so in a format that detainees with disabilities would be able to understand it. The interviews of random, LEP and Disabled detainees also confirmed they had received such information in a format they could understand. Staff interviews indicated that staff would read the sexual abuse orientation program to detainees who are blind, have sign language interpreters for detainees who are deaf, have Medical and Mental Health staff communicate with detainees who have intellectual, psychiatric or have speech disabilities and have audio available for detainees who have limited reading skills. The Auditors reviewed the educational material given to detainees which includes the Detainee Handbook that is given in the preferred language of the detainee.
(c) The Auditors reviewed documentation of one of the detainees Personal Property Record sheet. This form indicates the detainee received a video orientation as well as verbal orientation. Policy PIDC 4.5.13 requires documentation is kept of detainee orientation.
(d, e) The Auditors observed on the tour posted throughout the facility the DHS-prescribed sexual assault awareness notice, the name of the PIDC's PSA Compliance Manager and the names of 3 local organizations that are available to assist detainees who have been victims of sexual abuse.
(f) The Auditors reviewed the PIDC Detainee Handbook. PIDC provides this handbook to all detainees in the language of their preference. Detainee Interviews corroborated this facility practice.

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

(a, b) Policy PIDC 4.5.13 indicates all sexual abuse allegations must be handled and investigated following the guidelines set in ICE policy 11062.2. This policy describes that all allegations of sexual abuse will be referred to OPR who will then investigate as appropriately or refer to the facility. The Auditors reviewed the specialized training curriculum and received copies of two certificates of completion of this training, (b) (6), (b) (7)(C) from PIDC and (b) (6), (b) (7)(C) from OPR. PIDC staff to include (b) (6), (b) (7)(C) did not perform any sexual abuse investigations during the three-year Audit period. OPR investigated two allegations that were reported on 10/26/2015 and 3/1/2016. PSA Compliance Manager (b) (6), (b) (7)(C) is qualified to conduct Administrative investigations if the need was warranted from either of these allegations.

§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:

(a, b, c) ICE Health Service Corps (IHSC) Directive 11738.3 states that all IHSC staff to include contracted staff will receive training in the requirements of section b (1-4). Medical staff interviews verified this training in addition to the training for all staff in reference to standard 115.31. The Auditors reviewed the training curriculum and it includes the components in section b (1-4). PIDC presented documentation of a sign-in sheet of its appropriate staff for this training. No staff at PIDC conduct forensic examinations. Detainees who would require a forensic exam would be taken to Valley Baptist hospital. PIDC has attempted to enter into a MOU with Valley Baptist hospital as verified through e-mail correspondence.

§115.41 – Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a, b) IHSC Directive 11744.2 Intake Screening and Intake Reviews states that all new detainee arrivals shall be assessed for a history of assaulting or attacking others, sex offenses and physical or emotional trauma due to abuse or victimization to include cerebral trauma or seizures. This directive also states the initial assessments shall be completed within 12 hours of admission and that the detainees have no interaction with the general population. Classification Supervisor interviews corroborated this practice. In addition, the Auditors reviewed documentation from the Staging and Processing Area from 2/12/2018 of where 14 new arrivals were assessed and stayed less than 12 hours in this initial area.
(c) PIDC risk assessments that are performed in conjunction by Classification and Medical staff include each of the nine components required of this section with the exception of #(7). Three samples of detainee assessments were reviewed and it was determined that #(7) which ask whether the detainee has self-identified as gay, lesbian, bi-sexual, transgender, intersex, or gender nonconforming is not met in its entirety. The Intake Health Screening form, which contains the medical portion of the assessment, asks whether the detainee is transgender, but does not address the other categories identified in #7 (gay, lesbian, bi-sexual, intersex, gender non-conforming). Asking the detainee whether s/he identifies with any of the categories in #7 gives the detainee the opportunity to self-identify, and provides the facility with the information it must consider in determining the detainee's risk for sexual victimization. Because the Intake Health Screening form, which is the component of PIDC's risk assessment process designed to cover #7 is not comprehensive of all categories, this section of the standard is non-compliant. To obtain minimal compliance, it is recommended that #(7) be added to the risk assessment process to allow for each detainee to self-identify as gay, lesbian, bisexual, transgender, intersex or gender-nonconforming. Although the remaining eight components are present either in the Classification worksheet or on the Intake Health Screening form, the observations by the Auditors and interviews with staff involved in completing both documents, did not allow for a comprehensive assessment of all components required by the standard to properly measure the risk level of victimization and/or abusiveness. Therefore, it is also recommended that consideration be given to develop a method to properly evaluate the responses of all the components required to measure risk of victimization and abusiveness. One method that would allow such would be to generate one document solely devoted to contain all required criteria to measure risk of victimization (Required in Section c) and risk of being sexually abusive (Required in section d) to be conducted and/or reviewed by one department to allow consistency in managing any potential high-risk detainees.
(d) The assessments provided within the Classification worksheet or on the Intake Health Screening form cover whether the detainee has prior violent offenses and history of prior institutional violence or sexual abuse.
(e) PIDC provided a log of detainees who were housed at the facility 60 days or longer. The Auditors randomly chose 1 detainee and PIDC provided documentation that he had received a re-assessment within the 60-90 day timeframe. It is recommended that Medical and Classification staff have a refresher of this standard to keep in mind that this section directs for re-assessments after the initial assessment is completed within 60-90 days in addition to whether relevant additional information is received or an incident involving the detainee occurs.
(f) The interviews of Intake and Classification staff along with the PAQ indicate that PIDC does not discipline detainees for refusing to answer the questions on section c (1, 7, 8, 9).
(g) Interviews of Intake and Classification staff along with the PAQ indicated that PIDC has appropriate controls of the questions asked from sections c and d. The PAQ also answered yes on having implemented appropriate controls on intake assessment questions.

§115.42 – Use of assessment information.

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

Notes:

(a) PIDC 4.5.13 states that detainees will be screened upon arrival and those that are high risk will be placed in the least restrictive housing that is available and that is appropriate. The Classification Supervisor and Intake Staff interview responses indicated the safety of each detainee is made on a case-by-case basis. While touring the medical area, the Medical staff described how individualized determinations are made to ensure the safety of each detainee.
(b) The Classification Supervisor interview indicated that the requirements of this section are made for transgender and intersex detainees. PIDC reported they have no detainees with this identity. Medical staff explained that transgender and intersex detainees are sometimes housed in the Medical Unit with the least restrictive housing possible to ensure safety.
(c) Staff interviews all corroborated that transgender and intersex detainees would shower separately from other detainees and are housed in the medical unit. Shower units in this area are single occupant.

§115.43 – Protective custody.

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

Notes:

(a) Policy PIDC 3.4.2 Administrative Segregation provides written procedures for reason detainees may be placed in Administrative Segregation. The PAQ states that this policy was developed in consultation with the ICE Enforcement and the Removal Operations.
(b, c) PIDC reported that no occurrences have happened to where any detainee was placed in Administrative Segregation due to a vulnerability to sexual abuse. The PAQ answered that the provisions of this section are used when Administrative Segregation is used to house vulnerable detainees.
(d) PIDC policy 3.4.2 Administrative Segregation directs the provisions of this section to include a supervisory staff must conduct a review within 72 hours of the detainee's placement in Administrative Segregation to determine if warranted and that a supervisory staff shall conduct a review after the detainee has spent 7 days in segregation and every week thereafter for the first 30 days and every 10 days thereafter. PIDC reported no occurrences and the PAQ corroborated their policy.
(e) PIDC 4.5.13 states that the FOD be notified within 72 hours after the initial placement of a vulnerable detainee into Administrative Segregation. PIDC reports no occurrences within the last 12 months.

§115.51 – Detainee reporting.

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

Notes:

(a)Facility policy PIDC 4.5.13 provides multiple ways for detainees to privately report sexual abuse. Information is posted throughout the facility of how detainees make calls to the required contacts of this section. The Auditors observed this information posted in all housing units by the detainee telephones. Staff and Detainee interviews confirmed knowledge of this information being available.
(b) PIDC uses the OIG as the reporting method for the entity outside of the agency. The information of how to make this contact is posted throughout the facility. It was found during the on-site visit during a test call made by the Auditors that detainees had to enter their personal pin number on the phone before use. The Auditors discussed this issue with PIDC staff and how the detainee should have the option to stay anonymous when making these calls. PIDC staff took immediate action and corrected this on the detainee phone system to where detainees do not have to enter their pin number to make these types of calls.
(c) PIDC 4.5.13 directs that staff accept reports made verbally, in writing, anonymously and from third parties. Staff interviews confirmed this requirement and documenting immediately. Detainee interviews indicated knowledge of these reporting choices.

§115.52 – Grievances.

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

Notes:

(a, b) PIDC Detainee Handbook states that detainees may file a formal grievance at any time during, after or in lieu of lodging an informal grievance or complaint. Staff interviews to include the Grievance Coordinator corroborated the requirements of these sections.
(c, d) PIDC policy 3.5.6 Grievance System Procedure directs for the identifying and handling of time-sensitive grievances by naming them emergency grievances that involve immediate threats to the detainee's health, safety, or welfare. This policy also requires Medical emergencies to be brought to the attention of proper Medical personnel for further assessment. The Grievance Coordinator interview corroborated this type of grievance. PIDC reported 0 occurrences within the last 12 months.
(e) PIDC 3.5.6 directs grievance responses be issued within 5 days. The policy also requires for responses to appeals to be answered within 15 days. The Grievance Coordinator interview indicated that the appeal process would be quicker than 30 days. The PAQ indicates that the facility sends all sexual abuse related grievances to the appropriate FOD at the end of the grievance process. PIDC reported no occurrences of grievances of this type within the last 12 months. It is recommended that PIDC add language in PIDC policy 3.5.6 that PIDC shall send grievances related to sexual abuse and the facility's decision to the appropriate ICE FOD at the end of the grievance process.
(f) PIDC 3.5.6 specifically states that detainees may obtain assistance from another detainee, the housing officer or other facility staff, family members or legal representatives to help prepare a grievance. The Grievance Coordinator interview corroborated this practice. PIDC reports no instances in the last 12 months.

§115.53 – Detainee access to outside confidential support services.

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

Notes:

(a) PIDC has agreements with community crisis counseling services that include Family Crisis Center, Inc., Friendship of Women, and the Women Together/Mujers Unidas center. PSA Compliance Manager interview confirmed these services are available and the information is given out to the detainees through the Detainee Handbook and posted throughout the facility.
(b) PIDC policy 4.5.13 includes the community crisis centers in its prevention and intervention services. PSA interview confirmed these services. The Auditors contacted the Family Crisis Center and confirmed the availability of services.
(c) PIDC informs detainees about outside local organizations by posting the contact information throughout the facility which includes telephone numbers and e-mail addresses. The PAQ states that communication with these services enable reasonable confidential communication.
(d) PIDC provides a notice of confidentiality in the Detainee Handbook about a need to know basis of allegations of Sexual Abuse. It is recommended that PIDC provide a more detailed description including the mandatory reporting laws to which reports of abuse would be forwarded to authorities. A recommendation was made that they include this information at the bottom of the document with the names of the local crisis counseling centers.

§115.54 – Third-party reporting

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

Notes:

PIDC policy 4.5.13 directs that the information concerning the OIG hotline be posted in every housing unit. The agency website has the toll-free number to the OIG as well for family members, friends, etc. to call and report.

§115.61 – Staff reporting duties.

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

Notes:

(a, b, c) ICE policy 11062.2 and PIDC policy 4.5.13 direct the specific language from these sections of this standard. The PSA and random security staff interviews corroborated they understood the requirements of reporting as well as the need to keep the information confidential. It is recommended that PIDC specifically write this requirement in its appropriate policy to include all the requirements of reporting and confidentiality involved.
(d) The facility does not house juveniles. However, PIDC 4.5.13 does require reporting to designated state and local services agency (as necessary under applicable mandatory reporting laws) an allegation when the alleged victim is determined to be a vulnerable adult.

§115.62 – Protection duties.

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

Notes:

ICE policy 11062.2 directs the specific language from this standard. Staff interviews indicated they knew and understood the responsibility to immediately protect a detainee who is subject to a substantial risk of imminent sexual abuse.

§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:

(a, b, c, d) ICE policy 11062.2 uses the direct language from these 4 sections. The OIC and PSA interviews corroborated this would occur however PIDC reports 0 occurrences within the last 12 months.

§115.64 – Responder duties.

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

Notes:

(a, b) PIDC policy 4.5.13 specifically uses language from all of the requirements of each section of this standard. Staff interviews indicated they knew their responsibilities when learning of an allegation that a detainee was sexually abused.

§115.65 – Coordinated response.

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

Notes:

(a, b) PIDC policy 4.5.13 specifically directs the language from these sections of this standard. OIC interview confirmed this facility approach to having a written plan to coordinate actions in an incident of sexual abuse.
(c, d) PIDC PAQ states that the facility would report under the guidelines of these sections to the facility of where the victim is transferred. The OIC interview confirmed PIDC would follow these guidelines to the receiving facility of where the victim was transferred. PIDC reports no occurrences in the last 12 months. It is recommended that PIDC incorporate language from this section in the appropriate policy.

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

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

Notes:

ICE policy 11062.2 uses the specific language from this standard which includes the removal from duties of staff, contractors and volunteers suspected of perpetrating sexual abuse pending the outcome of an investigation. The OIC interview corroborated this practice. PIDC reports no occurrences in the last 12 months.

§115.67 – Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) ICE policy 11062.2 uses the direct language from this standard.
(b, c) Because PIDC reported no occurrences within the last 12 months, the Auditors reviewed two investigations of allegations of sexual abuse occurring during the three years preceding the audit, on 10/26/2015 and 3/1/2016. The Auditors were not provided any documentation that supported that monitoring occurred for the appropriate detainees following the reports of sexual abuse. Therefore, this standard is found to be non-compliant. The auditors received documentation on April 9, 2018 that a facility departmental form had been created to ensure future compliance.

§115.68 – Post-allegation protective custody.

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

Notes:

(a, b) PIDC 4.5.13 uses the specific language in these sections. PIDC reports no occurrences within the last 12 months.
(c, d) PIDC reports no occurrences in the last 12 months. The PAQ states that PIDC staff do properly reassess a detainee in protective custody who is a victim of sexual abuse before returning them to general population and that the re-assessment takes into consideration any increased vulnerability. The PSA interview indicated that a notification is made to the ICE FOD whenever a detainee victim has been held in Administrative segregation for 72 hours. It is recommended to add language from section (d) in PIDC's appropriate policy.

§115.71 – Criminal and administrative investigations.

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

Notes:

(a, b) ICE policy 11062.2 states detainee sexual abuse investigations will be prompt, thorough, objective and conducted by qualified investigators. PIDC policy 4.5.13 states allegations of sexual abuse or assault will be immediately reported and investigated. PIDC reports no allegations or investigations in the last 12 months, however, in the last 3 years 2 investigations have occurred. The dates are from 10/26/2015 and 3/1/2016, and both were found to be unsubstantiated. Neither of the two investigations were conducted by the facility staff; however, the facility has one staff member who has attended specialized training.
(c) PIDC policy 4.5.13 uses the direct language from this section to ensure all the provisions are used in Administrative investigations. PIDC reports no Administrative investigations in the last three years. The two reported investigations of 10/26/2015 and 3/1/2016 were investigated by OPR and determined to be unsubstantiated which doesn't necessarily require an Administrative investigation.
(d) All facility policies are reviewed and approved by ICE. ICE policy 11062.2 states that internal Administrative investigations are coordinated to ensure non-interference with criminal investigations by outside investigators.
(e) Agency policy SAAPI 11062.2 specifies that the departure of the alleged victim or abuser from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.
(f) Agency policy SAAPI 11062.2 specifies that when outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed of the progress of the investigation.

§115.72 – Evidentiary standard for administrative investigations.

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

Notes:

ICE Policy 11062.2 states that Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse or assault. PIDC reported 0 occurrences in the last 12 months but there were 2 investigations in the last 3 years. 1 from 10/26/2015 and 1 from 3/1/2016. Both of these were investigated by OPR and resulted in no administrative investigation needed. The PIDC PAQ also states that administrative investigations impose no standard higher than a preponderance of the evidence to determine whether allegations of sexual abuse are substantiated.

§115.73 – Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

PIDC reported no occurrences in the last 12 months but 2 investigations have occurred within the last 3 years. One from 10/26/2015 and 1 from 3/1/2016. No documentation of notifications was provided. The Auditors reviewed on-site that the alleged detainee victim in the 3/1/2016 was released from immigration detention before the investigation was closed, so no notification was applicable. PIDC was unable to provide verification on the investigation from 10/26/2015 as to whether the detainee was released before the close of the investigation or whether the detainee was actually informed before release. On April 9, 2018 the Auditors received documentation that did not provide adequate information that the detainee victim from the report on 10/16/2015 was released before the investigation was ended or that the detainee did receive notification of the outcome as required by this standard. Therefore, this standard is found to be non-compliant. A recommendation for potential compliance may include adding language to a checklist or coordinated response plan that ensures detainees receive the required notification.

§115.76 – Disciplinary sanctions for staff.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)PIDC's PAQ states that staff are subject to disciplinary or adverse action up to and including removal from their position for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies. PIDC reports no occurrences within the last 12 months. The OIC interview indicated this as well.
(b) PIDC policy 4.5.13 states that staff will be removed from duties from allegations of sexual abuse pending the result of the investigation and that staff who violate agency sexual abuse policies will receive disciplinary actions including up to dismissal. However, this facility policy does not specify the removal from their position and from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse. Therefore, this section is non-compliant. Recommendation of revising the policy to incorporate requisite language.
(c, d) PIDC provided ICE policy 11062.2 which specifically states that each facility shall report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to the local law enforcement agency and to any relevant licensing bodies, to the extent known. The OIC interview confirmed this process would occur if an incident arose. PIDC reports no occurrences in the last 12 months or three years.

§115.77 – Corrective action for contractors and volunteers.

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

Notes:

(a, b,) ICE policy 11062.2 and PIDC policy 4.5.13 directs that contractors and volunteers who are suspected of perpetration or have engaged in sexual abuse are removed from duties and are prohibited from contact with detainees. ICE policy 11062.2 also directs that criminal acts are reported to the local law enforcement agency. The OIC interview corroborated these are the practices of the facility to include they would report any act that was applicable to relevant licensing bodies involving the staff perpetrator.
(c) The OIC interview led to discussion that the facility would consider prohibiting contact from a contractor or volunteer with detainees, who did not engage in sexual abuse but did violate other provisions within the standards. The PAQ stated this as well.

§115.78 – Disciplinary sanctions for detainees.

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

Notes:

(a, b, c, d, e, f) PIDC policy 4.5.13 and the Detainee Handbook cover all the sections of this standard including that the facility subjects detainees to a formal disciplinary process following administrative or criminal findings of sexual abuse. The disciplinary process has sanctions commensurate with the severity of the prohibited act which include progressive levels of reviews, appeals, procedures and documentation. In addition, the disciplinary process considers the mental disability or illness when determining sanctions imposed on perpetrators. Discipline is not imposed for detainees for sexual contact with staff unless the staff did not consent and that sexual abuse allegations made in good faith does not constitute falsely reporting or lying. The OIC interview corroborated these practices of the facility. PIDC reports no occurrences within the last 12 months.

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

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

Notes:

(a)PIDC 4.5.13 directs that detainees at high risk for sexual victimization or high risk to commit sexual assault will be assessed by a mental health staff or other qualified staff. Medical and Mental Health staff interviews corroborated this practice.
(b, c) PIDC provided IHSC directives 03-10 and 07-02 which specify that when referrals for medical follow-up are initiated, the detainee shall receive them within two working days, and that mental health follow-ups are completed within 72 hours. Medical and Mental Health staff interviews corroborated this practice. Also, the audit team reviewed documentation on site that supported that both medical and mental health follow-ups were being conducted in the time frames required.

§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:

PIDC provided the IHSC directive 03-01 which specifies that detainee 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 and without cost to the victim regardless whether the victim names the abuser or cooperates with any investigation from the incident. PIDC reports no occurrences within the last 12 months. Two sexual abuse allegations have occurred within the last three years. The Auditors reviewed both of these incidents and neither were applicable for the alleged victim to receive medical treatment.

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

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

Notes:

(a) PIDC policy 4.5.13 states the facility shall offer medical and mental health evaluations and if appropriate, treatment to all detainees who have been victimized by sexual abuse in immigration detention. Medical and Mental Health staff interviews corroborated this practice. PIDC reports no occurrences within the last 12 months.
(b) PIDC policy 4.5.13 directs that evaluation and treatment of sexual abuse victims receive, as appropriate, follow-up services, treatment plans, and referrals for continued care when transferred or release from the facility. PIDC reports no occurrences.
(c) PIDC policy 4.5.13 directs that detainee victims of sexual abuse are provided medical and mental health services consistent with the community level of care by the facility. Medical and Mental Health staff interviews corroborated these services are provided.
(d) PIDC provided as documentation the IHSC Directive 03-01 that states detainees of abusive vaginal penetration by a male abuser while incarcerated are offered pregnancy tests and if pregnancy results given comprehensive information about lawful pregnancy-related medical services and timely access to pregnancy-related medical services. Medical and Mental Health staff interviews corroborated. PIDC reported no occurrences.
(e) PIDC policy 4.5.13 states detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as appropriate. Medical and Mental Health staff interviews corroborated this practice. PIDC reports no occurrences within the last 12 months.
(f, g) PIDC provided IHSC Directive 03-01 that states that treatment services to sexual abuse victims will be offered whether the victim names the abuser or cooperates with the investigation. In addition, IHSC 03-01 states the facility will attempt to conduct all known detainee-on-detainee abusers within 60 days of learning of such history and offer treatment as deemed by mental health staff. PIDC reports no occurrences. Medical and Mental Health staff interviews corroborated this practice.

§115.86 – Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)PIDC reports no incidents with the last 12 months however, in the last 3 years 2 incidents were reported and investigated by the OPR. The report dates are 10/26/2015 and 3/1/2016. These both are sexual abuse allegations that were determined to be unsubstantiated. PIDC conducted incident reviews but much later than 30 days after the conclusion of the investigation. Therefore, this section is non-compliant.
(b) The Auditors reviewed the incident reviews and the facility forms used did incorporate all the required items to consider for the incident review. Documentation reviewed were the 2 investigations as reported in section (a).
(c) PIDC did not perform an annual review of all sexual abuse investigations and resulting incident reviews for 2015 and 2016. Each of these years PIDC had one incident that should have resulted in these annual reviews and as a result the findings of the annual review were not provided to the facility administrator, FOD or designee and the agency PSA coordinator. Therefore, this section is non-compliant.
As a recommendation for potential compliance, complete any incident reviews and/or applicable written reports, to include an annual review as required in section (c), resulting from current or future completed investigations in the time frame as outlined in the standard. If no incidents occur within the CAP period, recommend that applicable staff be trained in order to ensure future practice require incidents reviews are conducted in accordance with 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:

PIDC policy 4.5.13 directs PIDC to maintain the required items including documents from this standard in a secured location. The OIC or AOIC maintains these files and enter them into an electronic system that the OIG supervises. PSA interview corroborated.

§115.201 – Scope of audits.

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

Notes:

The Auditors had access to and the opportunity to observe all areas of the facility, review relevant documentation to complete a thorough audit of the facility, conduct private interviews with detainees and to receive confidential information or correspondence from detainees.

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.

Joseph Martin May 18, 2018

Auditor's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Joseph Z. Martin and Bryan Henson	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	270 625 (b) (6), (b)

AGENCY INFORMATION	
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)

FIELD OFFICE INFORMATION	
Name of Field Office:	San Antonio Field Office
Field Office Director:	Daniel Bible
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	
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:	27991 Buena Vista Road		
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:**	Officer in Charge (OIC)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	956-547-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer (SDDO)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	956-547-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) on-site audit of Port Isabel Detention Center (PIDC) was conducted on March 13-15, 2018 by Auditors Joseph Z. Martin and (b) (6), (b) (7)(C) contractors through Creative Corrections, LLC. The Audit revealed that the facility was non-compliant on six standards. They were 115.21, 115.41, 115.67, 115.73, 115.76 and 115.86. Standard 115.21 section (e) was found to be non-compliant due to PIDC had not requested local law enforcement to follow the requirements as outlined in section a-d of this standard. Standard 115.41 section (c) was found to be non-compliant as PIDC was not letting detainees self-identify as being lesbian, gay, bi-sexual, transgender or gender non-conforming. Standard 115.67 section (b and c) were found to be non-compliant as PIDC was not monitoring detainees who had allegedly suffered from sexual abuse and therefore not documenting such. Standard 115.73 was found to be non-compliant as PIDC was not notifying detainee victims of alleged sexual abuse of the outcome of the investigation. Standard 115.76 section (b) was found to be non-compliant as PIDC Policy 4.5.13 did not specify that the presumptive disciplinary sanctions for staff who engage, attempt to engage, or to have threatened sexual abuse are removed from their position. Standard 115.86 sections (a and c); Section (a) was found to be non-compliant as PIDC did not perform incident reviews within 30 days after the close of the investigation. Section (c) was found to be non-compliant as PIDC did perform annual reviews of its sexual abuse investigations or incident reviews nor did the facility provide such information to the agency PSA Coordinator. The Auditor received documentation of the corrective actions taken to bring these standards into compliance on November 19, 2018. Below is each standard with detail to what standard was non-compliant along with sections and explanation of what the facility did to become compliant.

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:

(a) IHSC 11738.3 Sexual or Physical Assault, Abuse and/or Neglect provides protocol that maximizes the potential for obtaining usable physical evidence for investigations. This policy was written in conjunction with the DHS. PIDC does not house juveniles.
(b) PIDC provides 3 different victim advocate services. They are Friendship of Women, Family Crisis Center and Women Together/Mujeres Unidas. PIDC 11738.3 states that Mental Health staff initiate outside services for victims of sexual abuse or sexual assault when indicated. PSA corroborated these services are readily available and information pertaining to them is posted.
(c) IHSC 11738.3 states that forensic examinations will be provided to detainee victims at no cost to the detainee. Medical Staff interviews corroborated that detainee victims would have access to forensic examinations and if a SAFE or SANE were to not be available, other qualified health care staff would perform the exam. Valley Baptist hospital provides access to Sexual Assault Nurse Examiners staff. The PSA provided this information.
(d) PIDC offers victim services from three community-based organizations and posts their contact information in the Detainee Handbook. They are Friendship of Women, Inc., Family Crisis Center and the Women Together/Mujeres Unidas Center. The Auditors contacted the Friendship of Women, Inc. who confirmed they provide victim advocate services to PIDC to include support during forensic exams and investigatory interview.
(e) During the on-site audit it was found that PIDC has not requested the local law enforcement to follow the requirements of sections (a,b,c,d) of this standard which direct for following a uniform evidence protocol for obtaining usable physical evidence for Administrative and Criminal investigations, utilizing available community resources and services providing crisis intervention and counseling, and for alleged detainee victims to undergo Forensic Examinations with the detainee's consent. On April 9, 2018 the Auditors received documentation that a Memorandum of Understanding had been developed between ICE, Enforcement and Removal Operations (ERO), San Antonio Field Office (SNA), PIDC, and the Cameron County Sheriff's Office. Although the memorandum of understanding (MOU) mentions the inclusion of a rape crisis center SAFE/SANE's, it does not request the outside investigative entity (Cameron County Sheriff's Office) follow the requirements of sections a-d as required in section e. Therefore, this section of the standard is non-compliant. For compliance, a recommendation would be for the facility to submit a separate request to follow all of the components of section 115.21 to the Cameron County Sheriff's Office. The Memorandum of Understanding (MOU) dated on January 2, 2018 between ICE, Enforcement and Removal Operations (ERO), San Antonio Field Office (SNA), PIDC and the Cameron County Sheriff's Office was provided during the corrective action period with a revision that includes the requirements of sections a-d when Cameron County Sheriff's Office is called upon to assist in areas of Rape Crisis. This MOU serves as the request required by 115.21 (e) and is now found to be compliant. The Auditors have also been provided the annual revision dated January 2, 2019 that also contains the same language.

§115. 41 - Assessment or 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) IHSC Directive 11744.2 Intake Screening and Intake Reviews states that all new detainee arrivals shall be assessed for a history of assaulting or attacking others, sex offenses and physical or emotional trauma due to abuse or victimization to include cerebral trauma or seizures. This directive also states the initial assessments shall be completed within 12 hours of admission and that the detainees have no interaction with the general population. Classification Supervisor interviews corroborated this practice. In addition, the Auditors reviewed documentation from the Staging and Processing Area from 2/12/2018 of where 14 new arrivals were assessed and stayed less than 12 hours in this initial area.

(c) PIDC risk assessments that are performed in conjunction by Classification and Medical staff include each of the nine components required of this section with the exception of #(7). Three samples of detainee assessments were reviewed and it was determined that #(7) which ask whether the detainee has self-identified as gay, lesbian, bi-sexual, transgender, intersex, or gender nonconforming is not met in its entirety. The Intake Health Screening form, which contains the medical portion of the assessment, asks whether the detainee is transgender, but does not address the other categories identified in #7 (gay, lesbian, bi-sexual, intersex, gender non-conforming). Asking the detainee whether s/he identifies with any of the categories in #7 gives the detainee the opportunity to self-identify, and provides the facility with the information it must consider in determining the detainee's risk for sexual victimization. Because the Intake Health Screening form, which is the component of PIDC's risk assessment process designed to cover #7 is not comprehensive of all categories, this section of the standard is non-compliant. To obtain minimal compliance, it is recommended that #(7) be added to the risk assessment process to allow for each detainee to self-identify as gay, lesbian, bisexual, transgender, intersex or gender-nonconforming. Although the remaining eight components are present either in the Classification worksheet or on the Intake Health Screening form, the observations by the Auditors and interviews with staff involved in completing both documents, did not allow for a comprehensive assessment of all components required by the standard to properly measure the risk level of victimization and/or abusiveness. Therefore, it is also recommended that consideration be given to develop a method to properly evaluate the responses of all the components required to measure risk of victimization and abusiveness. One method that would allow such would be to generate one document solely devoted to contain all required criteria to measure risk of victimization (Required in Section c) and risk of being sexually abusive (Required in section d) to be conducted and/or reviewed by one department to allow consistency in managing any potential high-risk detainees. PIDC Medical staff implemented logging all categories as required in section seven that includes documenting if the detainee identifies as gay, lesbian, bi-sexual, transgender, intersex or gender non-conforming. The Auditor reviewed an example Intake Health screening Form which allows for notes to be written.

(d) The assessments provided within the Classification worksheet or on the Intake Health Screening form cover whether the detainee has prior violent offenses and history of prior institutional violence or sexual abuse.

(e) PIDC provided a log of detainees who were housed at the facility 60 days or longer. The Auditors randomly chose 1 detainee and PIDC provided documentation that he had received a re-assessment within the 60-90 day timeframe. It is recommended that Medical and Classification staff have a refresher of this standard to keep in mind that this section directs for re-assessments after the initial assessment is completed within 60-90 days in addition to whether relevant additional information is received or an incident involving the detainee occurs.

(f) The interviews of Intake and Classification staff along with the PAQ indicate that PIDC does not discipline detainees for refusing to answer the questions on section c (1, 7, 8, 9).

(g) Interviews of Intake and Classification staff along with the PAQ indicated that PIDC has appropriate controls of the questions asked from sections c and d. The PAQ also answered yes on having implemented appropriate controls on intake assessment questions.

§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) ICE policy 11062.2 uses the direct language from this standard.

(b, c) Because PIDC reported no occurrences within the last 12 months, the Auditors reviewed two investigations of allegations of sexual abuse occurring during the three years preceding the audit, on 10/26/2015 and 3/1/2016. The Auditors were not provided any documentation that supported that monitoring occurred for the appropriate detainees following the reports of sexual abuse. Therefore, this standard is found to be non-compliant. The auditors received documentation on April 9, 2018 that a facility departmental form had been created to ensure future compliance. PIDC developed a facility form to ensure compliance of the requirements of these sections. On November 19, 2018 the Auditor again reviewed the departmental form to ensure compliance. The Auditor reviewed a blank copy of this form which incorporates all components when monitoring for retaliation.

§115. 73 - Reporting to detainees

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

Notes:

PIDC reported no occurrences in the last 12 months but 2 investigations have occurred within the last 3 years. One from 10/26/2015 and 1 from 3/1/2016. No documentation of notifications was provided. The Auditors reviewed on-site that the alleged detainee victim in the 3/1/2016 was released from immigration detention before the investigation was closed, so no notification was applicable. PIDC was unable to provide verification on the investigation from 10/26/2015 as to whether the detainee was released before the close of the investigation or whether the detainee was actually informed before release. On April 9, 2018 the Auditors received documentation that did not provide adequate information that the detainee victim from the report on 10/16/2015 was released before the investigation was ended or that the detainee did receive notification of the outcome as required by this standard. Therefore, this standard is found to be non-compliant. A recommendation for potential compliance may include adding language to a checklist or coordinated response plan that ensures detainees receive the required notification. The Auditor reviewed the "Agency Checklist for Responding to Allegations of Sexual Abuse or Assault at ICE Detention and Holding Facilities" and it includes notifying the detainee of investigation results and any responsive action taken for detainees still in ICE immigration detention or where otherwise feasible.

§115. 76 - Disciplinary sanctions for staff

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

Notes:

(a)PIDC's PAQ states that staff are subject to disciplinary or adverse action up to and including removal from their position for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies. PIDC reports no occurrences within the last 12 months. The OIC interview indicated this as well.
(b) PIDC policy 4.5.13 states that staff will be removed from duties from allegations of sexual abuse pending the result of the investigation and that staff who violate agency sexual abuse policies will receive disciplinary actions including up to dismissal. However, this facility policy does not specify the removal from their position and from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse. Therefore, this section is non-compliant. Recommendation of revising the policy to incorporate requisite language. The Auditor reviewed the revised PIDC policy 4.5.13 which states "staff will be subject to disciplinary or adverse action up to and including removal from their position and the 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 a staff member, contractor, or volunteer who have engaged in or attempted or threatened to engage in detainee sexual abuse. This revised policy demonstrates PIDC is now in compliance with this standard.
(c, d) PIDC provided ICE policy 11062.2 which specifically states that each facility shall report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to the local law enforcement agency and to any relevant licensing bodies, to the extent known. The OIC interview confirmed this process would occur if an incident arose. PIDC reports no occurrences in the last 12 months or three years.

§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 reports no incidents with the last 12 months however, in the last 3 years 2 incidents were reported and investigated by the OPR. The report dates are 10/26/2015 and 3/1/2016. These both are sexual abuse allegations that were determined to be unsubstantiated. PIDC conducted incident reviews but much later than 30 days after the conclusion of the investigation. Therefore, this section is non-compliant. PIDC created and implemented a Sexual Abuse and Assault Prevention and Intervention (SAAPI) tracker log which ensures all required steps of this standards are completed that includes 30 day Incident reviews and Annual Incident Reviews. PIDC also trained applicable staff on this requirement. The Auditor reviewed the Tracker log that ensures these requirements.
(b) The Auditors reviewed the incident reviews and the facility forms used did incorporate all the required items to consider for the incident review. Documentation reviewed were the 2 investigations as reported in section (a).
(c) PIDC did not perform an annual review of all sexual abuse investigations and resulting incident reviews for 2015 and 2016. Each of these years PIDC had one incident that should have resulted in these annual reviews and as a result the findings of the annual review were not provided to the facility administrator, FOD or designee and the agency PSA coordinator. Therefore, this section is non-compliant. As a recommendation for potential compliance, complete any incident reviews and/or applicable written reports, to include an annual review as required in section (c), resulting from current or future completed investigations in the time frame as outlined in the standard. If no incidents occur within the CAP period, recommend that applicable staff be trained in order to ensure future practice require incidents reviews are conducted in accordance with this standard. PIDC created and implemented a Sexual Abuse and Assault Prevention and Intervention (SAAPI) tracker log which ensures all required steps of this standards are completed that includes 30 day Incident reviews and Annual Incident Reviews. PIDC also trained applicable staff on this requirement. The Auditor reviewed the Tracker log that ensures these requirements.

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.

Joseph Martin/Bryan Henson February 7, 2019

Auditor's Signature & Date