PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	12/7/2021	**To:**	12/9/2021
AUDITOR INFORMATION			
Name of auditor:	William Peck	**Organization:**	Creative Corrections, LLC
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	901-378-(b)(6), (b)
PROGRAM MANAGER INFORMATION			
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Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	722-579-(b)(6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	New Orleans Field Office
Field Office Director:	AFOD (b)(6), (b)(7)(C)
ERO PREA Field Coordinator:	SDDO (b) (6), (b) (7)(C)
Field Office HQ physical address:	1250 Poydras St. New Orleans, LA 70113
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:	River Correctional Center		
Physical address:	6362 Hwy 15 Ferriday, Louisiana (LA) 71334		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	318-757-0622		
Facility type:	D-IGSA		
PREA Incorporation Date:	2/1/2019		
Facility Leadership			
Name of Officer in Charge:	Steven DeBellevue	**Title:**	Warden
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	318-757-(b)(6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	318-757-(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 Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the River Correctional Center (RCC) was conducted December 7 - December 9, 2021, by U.S. Department of Justice (DOJ) and U.S. DHS certified PREA Auditor, William Peck for Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C) who also provided on-site guidance; both are DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Review and Analysis Unit (ERAU) section during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The RCC is privately owned by LaSalle Corrections and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at RCC are from Brazil, Haiti, and Venezuela. The facility does not house juveniles or family detainees. This was the first DHS PREA audit for RCC and included a review of the 12-month audit period from 12/6/20 through 12/6/2021. RCC is in Ferriday, LA.

Approximately two weeks prior to the audit, ERAU Team Lead (b) (6), (b) (7)(C) provided the APM and Lead Auditor with the facility's 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 and within folders for ease of auditing. The main policies that provide facility direction for PREA is LaSalle Corrections Corporate Policy 2.11 PREA Sexual Abuse Assault Prevention and Intervention (SAAPI), and DHS ICE policy 11062.2 SAAPI. All the documentation, policies, and PAQ was reviewed by the Lead Auditor and APM. The APM and Lead Auditor communicated with the ERAU Team Lead requesting further documentation for clarification and review during the on-site audit. Responses to the requests were provided by facility staff. Facility staff also provided additional documentation via email post on-site audit.

The entry briefing was held in an RCC Conference room at 8:00 am on Tuesday, December 7, 2021. In attendance were: ·

(b) (6), (b) (7)(C) ICE/OPR/Inspections and Compliance Specialist (ICS)
(b) (6), (b) (7)(C) ICE/OPR (ICS)
Steven DeBellevue, Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) Prevention of Sexual Assault (PSA) Compliance Manager
(b) (6), (b) (7)(C) Compliance Manger, LaSalle Corrections
(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO)
(b) (6), (b) (7)(C) Operational Review Director, LaSalle Corrections
(b) (6), (b) (7)(C) Health Services Administrator (HSA)
(b) (6), (b) (7)(C) Chief of Security
(b) (6), (b) (7)(C) Office Manager
(b) (6), (b) (7)(C) Release/Classification/Booking Lieutenant
(b) (6), (b) (7)(C) Lieutenant
(b) (6), (b) (7)(C) Fire and Safety Manager
(b) (6), (b) (7)(C) Richwood Compliance Manager
(b) (6), (b) (7)(C) Director of Nursing
William Peck, Certified DOJ/DHS Auditor, Creative Corrections, LLC
(b) (6), (b) (7)(C) APM/Certified DOJ/DHS Auditor, Creative Corrections, LLC

The APM and Lead Auditor introduced themselves and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The APM explained that the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. She further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews. It was shared that no correspondence was received from any detainee, outside individual, or staff member.

The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific category) including an alpha and housing listing of all detainees housed at the facility, both random, and from specific

categories. Lists of staff by duty position and shifts was also provided. Shifts are 0500-1700 and 1700-0500 with a muster 15 minutes prior to assumption of duties. Due to the ongoing pandemic, there were zero volunteers at the facility during the on-site visit.

A facility tour was completed by the APM and Lead Auditor with key staff. All housing units were toured, as well as, program areas, service areas, food service, control centers, booking/intake, recreation areas, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or provided services was observed by the APM and Lead Auditor. (b) (7)(E) Sight lines were closely examined, as was the potential for blind spots, throughout the areas where the detainees are housed or have accessibility. The Auditors spoke to random staff and detainees regarding PREA education and facility practices during the tour. Review of the housing unit logbooks was conducted to verify staff rounds for security staff and supervisors. It should be noted that a review of the logbooks covering five days supported that shift supervisors were making the required rounds but there were no records of rounds after 12:30 am. The APM suggested that the facility conduct rounds on the overnight, and/or make sure rounds being made are properly documented, which was ultimately addressed by the facility and further detailed in the related 115.13 standard narrative below.

The facility contracted with ICE in February of 2019. The facility is a single-story building. The facility has a design capacity of 602 adults. The custody level is low. The facility houses no female detainees or juveniles. On the first day of the audit, the facility population was 315 male detainees. The average detainee population for the last twelve months was 208. The average time in custody is 61 days.

The physical plant consists of two primary buildings, one of which is for support only. The primary confinement building has a capacity of 602 beds provided via eight open bay/dormitory housing units ranging from 72-74 beds each and two cell housing units. There are a total of eight segregation cells under direct supervision and two special watch cells available (SW1, SW2). The Auditors were informed that two housing units, Hotel Units B and C, would not be available to tour due to positive COVID-19 related issues. The PSA Compliance Manager advised the APM and Lead Auditor that these units mirrored the other units toured. The APM and Lead Auditor were able to view both these in the control center which had clear sight of the dorm area.

(b) (7)(E)
(b) (7)(E) All showers have privacy curtains. Phones are available for the detainees which allows reporting accessibility. Signs are posted above the phones that state "Phone calls are subject to monitoring at all times." PREA information posters/brochures posted on the bulletin boards include the PREA posters, information on correspondence including addresses and numbers, how to report outside the facility, foreign consulates with addresses and phone numbers, and the notification of audit. The dorms also had a binder in which this information was kept in duplicate should a detainee wish to individually use the information in his bed area or at the phone. The victim services information for Winn Community Center (Winn) was not posted; however, the facility posted the information, including address, telephone number, and mandatory reporting requirements prior to the exit briefing.

Detainees work in the kitchen and laundry areas. The kitchen is staffed with staff members and detainees. Meals are prepared in the kitchen and delivered to the dorms. The coolers and freezers are always locked and opened only by staff. Detainees are directly supervised while in these areas. (b) (7)(E) (b) (7)(E)

During the tour, the APM and Lead Auditor identified sight line concerns in two areas of the facility: the kitchen and special watch cells one and two (SW1, SW2). The SW1 and SW2 cells, which are subject to direct supervision by staff assigned to Central Control Two (CS2), had potential cross gender viewing issues when occupied by detainees. Although the staff informed the APM and Lead Auditor that a portable vision barrier was put into place when these cells are utilized, policy to ensure that the barriers are used appeared somewhat weak. It was recommended by the Lead Auditor that the shift supervisor make a special log entry verifying use of the barrier when the cell is occupied for suicide, etc. In the kitchen, the APM noted that the detainee restroom was unlocked which could potentially lead to an incident of sexual abuse. The APM recommended that the door be always secured, giving staff the ability to control who enters and when.

The facility's camera system was installed in 2001 and updated in the years 2019 and 2020. (b) (7)(E) . (b) (7)(E) The cameras do not have sound capability. The cameras are monitored through four central control centers. The APM and Lead Auditor observed the camera monitoring displays in all control centers. (b) (7)(E) Cameras operate 24/7 and can Pan, Tilt and Zoom (PTZ).

There were 21 formal detainee interviews during the on-site visit, randomly selected from the housing units. Interviewees were virtually all limited English proficient (LEP) and required the use of Language Services Associates (LSA), a contract language interpretative service provided through Creative Corrections. Detainees interviewed consisted of 9 random detainees, 10 Limited English Proficient detainees, and 2 detainees who reported a history of prior sexual victimization. A total of 25 staff and three contract employees were interviewed. The staff interviewed included 12 random staff, and 13 specialized staff, including the Warden, PSA Compliance Manager, first line supervisors (3), Grievance Coordinator, Classification Supervisor, Classification staff (1), Office Manager/Human Resources Supervisor, facility investigator, Training Supervisor, Intake Supervisor, and Intake staff (1). Contract employees from Family Solutions were also interviewed, including a Mental Health Counselor/LPC, HSA, and a Medical Nurse. Due to the pandemic, there were zero volunteers at the facility to be interviewed.

The facility uses six trained investigators to complete all allegations of sexual abuse. There was one sexual abuse allegation of staff-on-detainee sexual abuse reported during the audit period. It was referred to ICE OPR and determined to be unfounded after investigation by the RCC investigator.

On December 9, 2021, an exit briefing was conducted by the Lead Auditor in the Conference area. In attendance were:

(b) (6), (b) (7)(C) ICE/OPR/ICS
(b) (6), (b) (7)(C) ICE/OPR/ICS
Steven DeBellevue, Warden
(b) (6), (b) (7)(C) Assistant Warden
(b) (6), (b) (7)(C) PSA Compliance Manager
(b) (6), (b) (7)(C) Assistant Compliance Manager (ACM)
(b) (6), (b) (7)(C) Chief of Security
(b) (6), (b) (7)(C) Office Manager
(b) (6), (b) (7)(C) Fire and Safety Manager
William Peck, Certified DOJ/DHS Auditor, Creative Corrections, LLC
(b) (6), (b) (7)(C) APM/Certified DOJ/DHS Auditor, Creative Corrections, LLC.

The Lead Auditor spoke briefly about the staff and detainee knowledge of the RCC PREA zero-tolerance policy. The Lead Auditor informed those present that it was too early in the process to formalize an outcome of the audit, and that he would need to review all submitted documentation and interview notes conducted with staff and detainees. The Lead Auditor explained the audit report process, timeframes, and thanked all present for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

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

Number of Standards Met: 32
§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
§115.18 Upgrades to facilities and technologies
§115.31 Staff Training
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.43 Protective custody
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff Reporting Duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder Duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of Audits

Number of Standards Not Met: 8
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.51 Detainee reporting
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

PROVISIONS

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

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

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

Notes:

(c): The facility follows LaSalle Corporate written policy 2.11, Sexual Abuse and Assault Prevention and Intervention (SAAPI), mandating zero-tolerance towards all forms of sexual abuse and sexual harassment. Policy 2.11 outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment and provides definitions of sexual abuse and general PREA definitions. In an interview with the facility Warden, it was confirmed that policy 2.11 was reviewed and approved by ICE as required by the standard. During the on-site visit, the APM and Lead Auditor observed on the housing unit bulletin boards, and in other locations throughout the facility, signage that included the ICE Zero-Tolerance posters. The Auditors also reviewed the facility handbook, ICE National Detainee Handbook, and the DHS-prescribed Sexual Assault Awareness Information pamphlet handed out at intake. Formal and informal interviews with staff, and detainees, further confirmed RCC's commitment to zero tolerance of sexual abuse.

(d): Per policy 2.11, the facility's PSA Compliance Manager, "is responsible to assist with the development of written policies and procedures for the Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program, to assist with the development of initial and ongoing PREA training protocols, to serve as a PREA liaison with other agencies, to coordinate the gathering of statistics and reports on allegations of sexual abuse or assault, to review the results of investigations of sexual abuse and assist in conducting an annual review of all investigations to assess and improve prevention and response efforts, and to review facility practices to ensure required levels of confidentiality are maintained." The facility's Warden appointed a PSA Compliance Manager at the supervisory level who oversees the facility's compliance efforts with the implementation of PREA. The Lead Auditor determined compliance through the review of policy 2.11 and an interview with the PSA Compliance Manager. A review of the organizational chart confirms that the PSA Compliance Manager reports to the Warden. The PSA Compliance Manager, during interview, confirmed he has sufficient time and authority to oversee facility efforts to comply with the SAAPI policy.

§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)(c): A review of the updated PAQ indicated RCC has a total of 103 security staff, consisting of 59 males and 44 females, that may have recurring contact with detainees. The remaining staff consists of approximately 11 support personnel in Administration, Food Service, Maintenance, and Religious Services. The facility also employs 17 medical and three mental health contract/personnel employed by Family Solutions. During the audit period, RCC line staff were working two 12-hour shifts. The Lead Auditor's interview with the Warden indicated the PREA staffing plan assessment, dated 6/10/21, took into account for the staffing levels at RCC: generally accepted detention and correctional practices, any judicial finding 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 other relative factors, including but not limited to, the length of time detainees spend in agency custody. During the on-site audit, there was conflicting information provided during interviews on whether the number of staff is determined by an established staff to detainee ratio per se, but the Lead Auditor determined that the physical layout, size of the facility, and the composition of the detainee population were primary factors. The Lead Auditor observed staffing levels during the on-site audit and determined they were adequate. (b) (7)(E) [redacted] Video cameras operate 24-hours a day, 7 days a week. Cameras are continuously monitored in the four Control Rooms and the Investigators also have full access with the ability to save footage in the evidence locker and to burn DVDs. The Warden, and PSA Compliance Manager, interviews reported that, in determining adequate levels of detainee supervision and determining the need for video monitoring, the facility takes into consideration all requirements of the standard. The Warden, and Lead Investigator, report high satisfaction with the quality and coverage of the cameras. In addition, the Warden indicated he considers camera placement during his routine walks about the facility, and reports, excellent corporate support for any additions he requests. New cameras were installed during both 2019 and 2020 and, also in 2020, additional mirrors were put in place to increase vision in areas needing more coverage.

Recommendation: The Lead Auditor recommends that the facility improve how they document the elements required in subsection (c) by developing a means, i. e. checklist, or narrative to confirm all elements of subsection (c) were considered.

(b)(d): Policy 2.11, and facility post orders, outline the comprehensive detainee supervision guidelines to meet detainee supervision needs. Policy 2.11 "requires staff, including supervisors, to conduct frequent unannounced security inspection rounds to identify and deter sexual abuse of detainees." Policy 2.11 further requires that "the occurrence of such rounds shall be documented in the applicable log as "PREA Rounds" and will be conducted on all shifts (to include night, as well as day) in all areas where detainees are permitted, and employees shall be prohibited from alerting other employees that supervisory rounds are occurring unless such

announcement is related to the legitimate operational functions of the facility." The post orders outline the responsibilities of detainee supervision including the requirement to make several rounds of the housing units but do not specifically require unannounced rounds of either the Lieutenant, Shift Supervisor, or of the Sergeant. In addition, documentation submitted, via email post on-site audit, confirmed the supervision guidelines (post orders) are reviewed by the Chief of Security and distributed on an annual basis. The Lead Auditor interviewed a random Lieutenant and Sergeant from each shift, who indicated that they made their rounds during their shift as required. A five-day review of logs by the APM confirmed that unannounced rounds are conducted on each shift, however, although the standard does not dictate the number of rounds, or how often they occur, the APM suggested that rounds be conducted post 12:30 am and that they be better documented. After the on-site visit, copies of log entries covering five days were submitted, via email, to the Lead Auditor showing prior recorded rounds being made after midnight. The facility is in compliance with subsection (d) of the standard, but they agreed the logging of the rounds will be more emphasized and better recorded.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b)(c): RCC does not house juvenile and family detainees. A review of the PAQ, a Warden's memo, and an interview with the PSA Compliance Manager confirmed the facility does not house juveniles nor family detainee units.

§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)(d): Policy 2.11 states, "Pat searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required, or, in exigent circumstances." The Lead Auditor reviewed the cross-gender pat search log and confirmed all cross-gender searches would be logged in the event one occurs. The Training Supervisor indicated that RCC requires training (with a certificate) on communicating professionally with LGBTI detainees as well as on transgender and cross-gender searches. All staff interviewed indicated that cross-gender pat-down searches are not conducted on the detainees at RCC. They further indicated that they had not conducted, or were aware of, any cross-gender pat-down searches conducted during the audit period. This was further supported by a memo to file and the PAQ.

(c): RCC does not house female detainees; therefore, provision (c) is not applicable.

(e)(f): Policy 2.11 states, "Strip searches of detainees by staff of the opposite gender shall not be conducted except in exigent circumstances, or when performed by medical practitioners." Policy 2.11 requires "all strip searches to be documented and further states that "body-cavity searches will be conducted by a medical professional and must take place in an area that affords privacy." Interviews with line staff confirmed staff are aware of the facility's policy for conducting strip or body-cavity searches, and that if performed shall be approved by a supervisor and documented on an incident report. During the audit period, no cross-gender strip or body-cavity searches were conducted. This was documented through interviews with Lieutenant and Sergeant security supervisors, line staff, and review of the search log.

(g): Policy 2.11 states, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement." Policy 2.11 further states, "Employees of the opposite gender must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." Interviews with staff, and detainees, also confirmed the detainees have privacy for these functions. There are cells directly supervised by control center staff, SW1 and SW2, that could provide the potential to view detainees in an unclothed state or while using the toilet. Staff interviewed indicated a vision barrier is put into place when these cells are occupied but the facility could not confirm through documentation that the barrier was utilized on all occasions. Toilet and shower areas have functioning visual blocks and screens for privacy both by direct visual and on camera. Additionally, RCC practice, per staff interviews, is that detainees are not allowed outside the shower area unless dressed appropriately, so the dressing occurs behind the shower curtain. This requirement is in the RCC Handbook and is posted outside each shower. During the on-site visit, the Lead Auditor determined through observation that the detainees were able to shower, perform bodily functions, and change their clothing as dictated by the standard. During the interviews, female staff indicated they announce themselves when entering a living area and announcements being made by female staff were observed by the APM and Lead Auditor. In addition, many of the detainees interviewed indicated they recalled opposite gender staff announcing themselves on a regular basis.

(i): Policy 2.11 indicates, "The facility shall not search or physically exam a transgender or intersex detainee for the sole purpose of determining a detainee's genital status." It further states, "If a detainee's gender is unknown, it may be determined during conversation with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private, by a medical practitioner." No searches, for the sole purpose of determining a detainee's genital status, have occurred in the audit period per memo submitted with the PAQ and interviews with line and medical staff.

Recommendation: The Auditor recommends when special watch cells, SW1 and SW2, are in use that the erection of the vision barrier be logged and reviewed by a designated facility supervisor.

(j): A review of RCC's training curriculum, in addition to an interview of the Training Supervisor, confirms that security staff are trained to conduct all pat searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs, including consideration of officer safety. Interviews with the Training Supervisor and security line staff, the review of the training lesson plans, which reinforce these policies in the annual training, and the review of 10 security staff training records, confirmed that training is conducted as required by the standard. During the interviews with 12 random security staff, all but two indicated that they would use the "blade and back of hand" technique to reduce sensitivity and display respect to the detainees. Informal interviews with staff during the on-site portion of the audit further confirmed compliance with this section of the standard.

(h) RCC is not designated as a Family Residential Center; therefore, provision (h) is not applicable.

§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): Policy 2.11 dictates that "detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facilities efforts to prevent, detect, and respond to sexual abuse." Policy 2.11 further dictates that "when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall attempt to accommodate the detainee by providing access to in-person, telephonic, or video interpretive services, access to written materials related to sexual abuse in formats or through methods that ensure effective communication; and auxiliary aids such as readers, materials in Braille, audio recordings telephone handset amplifiers, telephone telecommunications devices for deaf persons (TTY's), interpreters, and note takers."

(c) In addition, policy 2.11 states that, "the facility will provide detainees who are LEP with language assistance, including bilingual staff, or professional, impartial interpretation and translation services, to provide them with meaningful access to its program and activities." Detainee interpreters, absent an emergency where an extended delay could compromise the detainee's safety, are not allowed and have not been utilized. The interviews with the Investigator, PSA Compliance Manager, and Warden all confirmed that detainees would never be involved in interpretation regarding sexual abuse, investigations, or medical issues. The language line contract, Language Line Services, is used when interpreter services are needed, and, according to an interview with the PSA Compliance Manager, and two Lieutenant shift supervisors, there is an additional list of local approved interpreters approved by the Warden.

There were zero intakes during the on-site visit; and therefore, the APM toured intake processing with the guidance of the Intake Supervisor who narrated step by step the intake process. In an interview with the Intake Supervisor, the APM was advised that upon intake, detainees are provided with both the ICE National Detainee Handbook and the RCC facility handbook. If a detainee requests an ICE Handbook in a language that is not covered by the hard cover handbooks on site, specifically English, Spanish, and Creole, a handbook in one of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese) would be printed out for the detainee. The facility handbook provides detainees with information on the Agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse. The facility handbook was primarily available in English, Creole, and Spanish. The orientation Lieutenant (Lt.) advised the APM that if the detainee does not speak one of the languages available, she would print out a version in his preferred language using google translation. The facility also has available the DHS-prescribed Sexual Assault Awareness Information pamphlet. The pamphlet is handed out at intake and is attached to the RCC handbook. It is available in nine languages and provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault. Languages are English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. The orientation Lt. also confirmed that all detainees view a PREA video upon intake that contains content related to the Agency and facility's sexual abuse program. The video is in both English and Spanish, and if a detainee spoke a language not covered by the video, or if the detainee was visually impaired, blind, or otherwise disabled, the orientation Lt. advised that staff serve as an interpreter, or the language line would be utilized. Supervisors interviewed were aware of the ability to print material in various languages from the ICE website, and they were also aware of the capability of TTY services for the deaf, use of readers, and computer access to sign language, etc. The APM reviewed 10 randomly chosen detainee files, all of which contained signed documentation indicating the distribution of the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the RCC facility handbook to the detainees. The interviews of 10 LEP detainees confirmed that they had received PREA information in a format they could understand. In addition, of the 21 detainees interviewed by the APM, and Lead Auditor, the majority indicated that they saw the PREA video and were able to understand it's content.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(e)(f): The Federal Statue 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. The ICE Personnel Security and Suitability Program policy outlines misconduct and criminal misconduct as

grounds for unsuitability, including material omissions or making false or misleading statements in the application. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Policy 2.11 requires "the facility, to the extent permitted by law, to decline to hire or promote any individual, and decline to enlist the services of any contractor or volunteer, who may have contact with detainees who: has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse" and requires that "the individual directly responds to questions about misconduct on form Self-Declaration of Sexual Abuse/Sexual Harassment. The signed Self-Declaration of Sexual Abuse/Sexual Harassment form is to be retained in the employee's personnel file." Additionally, the LaSalle Corporate employee handbook, and hiring documents, both require this continuing responsibility. RCC staff sign for receipt of this workbook and employee manual. The HR Director further noted that their HR policy states that "material omissions regarding conduct as outlined in subpart (a) of this standard, or giving false information, is grounds for termination or withdrawal of an offer for employment and that, unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer." During the on-site portion of the audit, the Lead Auditor reviewed nine randomly selected staff personnel files and determined that all files lacked the Self-Declaration of Sexual Abuse/Sexual Harassment form.

Does Not Meet (b): The facility, does not meet section (b) of the standard. Although there is a policy in place, RCC has not initiated the practice as outlined in the policy and required by subsection (b) of the standard. To become compliant, the facility must initiate the process to require all staff members to disclose any such misconduct annually using the Self-Declaration of Sexual Abuse/Sexual Harassment as directed by Policy 2.11.

(c)(d) Federal Statute 731.105 requires, "of all staff and contractors every five years." Policy 2.11 requires "RCC prior to hiring any employees who may have contact with detainees, perform a criminal background record check consistent with federal, state, and local law and make its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse as defined by this policy." The interview with the HR staff confirmed that individuals seeking employment, which includes contractors and employees, receive a background check prior to contact with any detainee. She further stated that background checks are conducted by ICE on all RCC employees and background checks on any volunteers or contractors would be done by the Concordia, Louisiana Parish Sheriff's Office (CPSO). These checks include credit history, motor vehicle history, all police contacts, and National Crime Information Center (NCIC) checks. Further, all employees will be required to receive a five-year background recheck when that date is reached. During the on-site portion of the audit, the Warden disclosed to the Lead Auditor that the facility's contract with ICE was not established until February 2019, and therefore, five-year background checks will not be due until 2024. The Auditor reviewed background check dates for three ICE employees and was provided dates the pre-hire background checks for RCC staff were completed. The three background checks are valid until 8/22/2022, 5/19/2025, and 10/27/2025.

§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): Policy 2.11 states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of the existing facilities, LaSalle shall consider the effect of the design, acquisition, expansion, or modification upon the company's ability to protect detainees from sexual abuse." Policy 2.11 further states, "When installing or updating a video monitoring system, electronic surveillance system or other monitoring technology, LaSalle shall consider how such technology may enhance their ability to protect detainees from sexual abuse." Documentation submitted with the PAQ indicated RCC determined during the annual PREA staffing assessment that the facility camera system needed improvement. The request to increase the number of cameras was approved and the cameras have been installed. An interview with the Warden confirmed these changes and that he considers camera placement every time he tours the facility. Documentation submitted with the PAQ, and an interview with the Warden, determined that RCC did not design or acquire any new facility or undergone any substantial expansion or modification during the audit period.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Policy 2.11 requires sexual abuse investigations "follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocols must be developmentally appropriate, be adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, 'A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,' or similarly comprehensive and authoritative protocols developed after 2011." In the Lead Auditor's interviews with the Warden, and Lead Investigator, it was confirmed that, although the Lead Investigator appeared to be knowledgeable, a facility evidence protocol was not developed as required by the standard.

The agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, "when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene

evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE Enforcement and Removal Operations (ERO) Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of the Inspector General (OIG), OPR, or the local law enforcement agency, the ICE AFOD would assign an administrative investigation to be conducted."

Does Not Meet (a): The facility has not developed an evidence protocol; and therefore, is not compliant with subpart (a) of the standard. To become compliant, the facility must develop a protocol that maximizes usable physical evidence for administrative proceedings and criminal prosecutions. In addition, the facility must train all applicable staff regarding the newly established protocol.

(b)(d): Policy 2.11 requires "RCC to attempt to make available to the victim a victim advocate from a rape crisis center. The investigating entity may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services." RCC has an MOU with the Winn Community Health Center (Winn), Winnfield, LA. The agreement in the MOU is for Winn to provide emotional support, crisis information, support at forensic actions and referrals. The MOU was entered into on October 8, 2021 and is continuous unless either party gives 30 days' notice to end the MOU. The Lead Auditor attempted on four separate occasions to contact Winn staff during the on-site audit; however, was unsuccessful, and therefore, the services provided by Winn, that were noted in the MOU, including anonymous reporting could not be confirmed.

(c): Policy 2.11 requires "victims of sexual abuse have access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate. A Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) shall perform such examinations where possible. If SAFEs or SANEs cannot be made available, other qualified medical practitioners can perform the examination. The investigating entity shall document its efforts to provide SAFEs or SANEs." According to the HSA, RCC does not perform forensic exams at the facility. Detainees needing this type of exam are sent to Trinity Medical Center based on RCC's MOU with Trinity, dated 3/10/2021. The agreement in the MOU is to provide emergency services, inpatient care, and a SANE for comprehensive care in sexual assault cases for facility detainees. The APM, and Lead Auditor, interviewed the facility HSA, and the mental health practitioner, both of whom confirmed detainees making an allegation would be sent to the hospital, if medically appropriate, and seen by a SANE practitioner. The HSA also confirmed detainee victims would never be charged for medical services related to victimization. The Lead Auditor's review of the single investigative file indicated that the detainee was not offered access to a forensic exam, should it have been appropriate, as he was not taken to medical by the supervisor as required, due to the alleged detainee victim indicating at the time of the incident that he did not require medical attention, even though transport to the medical department is a mandatory requirement. The Lead Auditor confirmed that not transporting the alleged detainee victim to the medical area was the result of staff not having an investigation protocol to follow if an alleged incident of sexual abuse should occur.

Does Not Meet (c): The facility does not meet subsection (c) of the standard. A review of the single sexual abuse investigation confirmed that facility staff did not take the detainee to medical as required by the standard; therefore, the detainee was not afforded access to a forensic exam should one have been appropriate. Although the detainee declined services to security, the detainee should have been escorted to medical to comply with the standard, and then declination of services given to medical staff, who could have appropriately documented the declination in the detainee's medical file. To become compliant the facility must develop a protocol that requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. In addition, the staff must be trained on the new protocol and the training must be documented.

(e): The facility has a 9/8/2021 MOU with the CPSO to conduct criminal investigations at RCC. The MOU requires CPSO to adhere to the requirements of subparts a-d of the standard. The MOU was initiated September 8, 2021, and is continuous unless either party gives 30 days' notice to end the MOU. The Lead Auditor's review of the single investigative file confirmed that the case was referred to the CPSO.

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

Outcome: Does Not Meet Standard (Requires Corrective Action)

Notes:

(a)(b)(d): The Agency has provided a written directive, Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention, section 5.7, page 11, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (b) (6), (b) (7)(C) Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." LaSalle Corporate policy 2.11 requires that "the facility administrator ensures that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault." Policy 2.11 further requires that "all criminal investigations be referred to a law enforcement agency with legal authority to conduct criminal investigations and that administrative investigations shall be conducted by the facility after consultation with the appropriate

investigative office within ICE/DHS, and the assigned criminal investigative entity." This understanding is outlined in the 9/8/2021 MOU with the CPSO. RCC does not, however, have an investigation protocol detailing the roles and responsibilities of both the facility and the investigating entity in performing sexual abuse investigations. According to the Warden, and the Lead Investigator, all investigations are reported to the JIC, entered the JIC Management System, and then assessed to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG and/or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor-on-detainee sexual abuse allegations. Once the investigation 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 investigation 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 in 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 Warden, and Lead Investigator, confirmed that every allegation of sexual abuse made must be investigated. The facility Lead Investigator confirmed in an interview that an administrative investigation is conducted on all allegations of sexual abuse after consultation with the investigative office within DHS and the CPSO. In addition, policy 2.11 dictates that "the facility shall retain reports of allegations in accordance with Policy 1-15 Retention of Records" which states, "PREA records shall be retained for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five years." Interviews with the Warden, PSA Compliance Manager, and facility investigator confirmed compliance with the standards requirement to retain all reports and referrals of allegations of sexual abuse for at least five years.

Does Not Meet (a)(b)(d): The facility is not in compliance with subsections (a)(b)(d) of the standard that requires the facility establish a protocol to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority as required in subsection (a) of the standard. As the facility does not have a protocol, the requirements of subsections (b)(d) that require what is included in the protocol is also non-compliant. To become compliant the facility must develop a protocol that includes all elements of subsections (b)(d) of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content.

(c) : During the APM's review of the RCC website it was determined that the website navigates to the Louisiana Department of Corrections (LDC) website doc.louisiana.gov which contains the LDC protocol. The Lead Auditor also reviewed the ICE website, (https://www.ice.gov/prea). Both websites provide the public with expected investigative protocols; however, the PREA information on the LDC website is difficult to navigate to and is not specific to RCC.

Does Not Meet (c): The facility is not compliant with subsection (c) of the standard. The investigation protocol located on the LDC website is not specific to RCC. To become compliant the facility must develop an investigation protocol and make it available to the public as required by the standard

(e)(f): Policy 2.11 requires that "when a detainee, or staff member, contractor, or volunteer, is alleged to be the perpetrator of sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility (ICE OPR) or the DHS Office of Inspector General (DHS OIG), as well as the appropriate ICE Field Office Director/designee." Both the Warden, and PSA Compliance Manager, confirmed this procedure and stated that the Warden would immediately report any sexual abuse incidents immediately to the ICE SDDO who would notify the JIC, the ICE OPR and/or the DHS OIG. The Lead Auditor's review of the one sexual abuse allegation reported during the audit period confirmed it was referred to the JIC, ICE OPR, the ICE Field Office Director, and the CPSO.

§115.31 - Staff training.

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

Notes:

(a)(b)(c): Policy 2.11 dictates how the facility trains all staff who may have contact with detainees and requires the training for all facility staff to be able to fulfill their responsibilities to include each element of the standard. Policy 2.11 states, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention SAAPI Program shall be included in the 90-hour training for all new employees and shall also be included in annual refresher/in-service training thereafter. Employee training must ensure facility staff are able to fulfill their responsibilities under DHS standards." During the Pre-Audit phase of documentation review, the Lead Auditor reviewed the RCC PREA training curriculum, and PREA lesson plans of 3/4/2020, and determined both to be compliant with the standard in all material ways. RCC utilizes a Preservice Workbook of staff training topics, provided by LaSalle Corrections, that clarifies the illegal nature of any detainee sexual contact or relationship, the immediate reporting requirement, and also includes the other required staff training items. Every RCC staff member hired is required to read and receipt for this workbook. This training is documented by staff signature and serves as acknowledgment of awareness of the content and the potential for criminal charges in the event of misconduct. The Lead Auditor randomly selected 10 staff training files, plus 5 ICE employee PREA training verifications from PALMS e-learning, to review training documentation of staff for proof of completion and determined the training was compliant per the standard's requirement. Staff training documentation is maintained within the staff training files. Interviews with the Training Supervisor confirmed staff receives the required PREA training and refresher training as required by the standard. Facility staff, in conjunction with policy 2.11, receive PREA training annually, plus an as-needed roll call training coverage of new areas or areas needing reinforcement or emphasis. The Lead Auditor was also provided with the PREA training records on five ICE employees who

have contact with detainees. Upon review, the Lead Auditor determined that the documentation provided confirmed that ICE staff also met the refresher requirement of the standard; however, received the training every two years instead of annually.

§115.32 - Other training.

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

Notes:

(a)(b)(c): Policy 2.11 outlines how the facility shall train, or require the training of, all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard. Policy 2.11 states, "The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed on how to report such incidents." The APM interviewed the facility's Training Supervisor, who is responsible for conducting volunteer and contractor training, and determined that contractors and volunteers receive the same level of PREA training that is provided to staff and acknowledge receipt of the training. The Lead Auditor was provided training certificates of three volunteers from the period prior to COVID-19 restrictions, and completed training for two CCTV/camera contractors, e.g., signed acknowledgments of training received and training session sign in sheets and determined that the facility was compliant in training contractors and volunteers who may have contact with immigration detainees.

§115.33 - Detainee education.

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

Notes:

(a)(b)(c)(e)(f): Policy 2.11 indicates that "during the intake process, all detainees shall be notified of the facility's zero-tolerance policy on sexual abuse and assault." The policy further indicates that "the facility will provide the information (orally and in writing) about the facility's SAAPI program" and "Detainee orientation and instruction must be in a language, or manner that the detainee understands, including for those who are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills." Documentation submitted with the PAQ indicates that PREA information was provided to detainees through the ICE Sexual Assault Awareness Information pamphlets, DHS posted signage "ICE Zero-Tolerance," the ICE National Detainee Handbook, and the RCC facility handbook. The ICE National Detainee Handbook is available in the following languages: English, Spanish, Arabic, Bengali, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Simplified Chinese, Turkish, and Vietnamese, as confirmed by the PSA Compliance Manager. The facility also has available the DHS-prescribed Sexual Assault Awareness Information pamphlet. The pamphlet is handed out at intake and is attached to the RCC handbook. It is available in nine languages and provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault. Languages are English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. The PSA Compliance Manager noted that these are both printed as needed. In addition, the facility provided a manuscript of the orientation video that confirmed all elements of the standard were covered. There were zero intakes during the on-site visit; and therefore, the APM toured intake processing with the guidance of the Intake Supervisor who narrated step by step the intake process. The Lt. in charge of orientation does an exceptional job, ensuring detainees are provided the information in a timely fashion according to the standard's requirements. During the Lt.'s interview, she indicated that she makes sure every detainee receives the information in their preferred language by using google translation services. It should be noted that she has the detainee sign for the PREA information on an English or Spanish form; therefore, even though the Lt. advised the detainee by use of Google Translation Services what he was signing for, the APM suggested that the form be developed for each language in which the material is received. The RCC facility handbook provides detainees with information on the agency and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse. The facility handbook is available in English, Spanish, and Creole. If the detainee does not speak one of the languages available, the orientation Lt. prints out a complete version of the information using google translation. All detainees who arrive together are housed separately together until the entire intake process is completed. Interviews with the orientation Lt. confirmed that the detainees are shown a video that is presented in English and in Spanish. The APM reviewed 10 randomly chosen detainee files which contained signed documentation indicating the distribution of the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the RCC facility handbook. The review of the 10 detainee files further confirmed, except for one file, that orientation is completed within the timeframe required by the standard and that the detainees sign that orientation had been received. The interviews of 10 LEP detainees indicated that they had received PREA information in a manner that they could understand. Of the 21 detainees interviewed by the Auditors, the majority indicated that they saw, and understood, the PREA video.

Recommendation: During the intake walkthrough, the Auditor learned detainees are required to sign for PREA information received on a form which is translated only in English and Spanish. The APM suggested the form be developed for each language the material is received or the interpreter line used is clearly indicated on the form.

(d): Policy 2.11 states, "The facility shall post on all housing unit bulletin boards the following notices: The DHS-prescribed sexual abuse and assault awareness notice; the name of the facility PSA Compliance Manager; and information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available). If no such local organizations exist, the facility shall make available the same information about national organizations." The facility provided the APM and Lead Auditor with an exhibit containing the documentation for review. During the on-site visit, the APM, and Lead Auditor, observed posting of the DHS-prescribed sexual assault awareness notice, and the name of the current PSA Compliance Manager. At the time of the on-site tour, the information for the local organization that could assist detainees who have been victims of sexual abuse was not posted. The facility posted the information for the Winn program on

the last day of the on-site audit. The information included the address, telephone number, and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

§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 2.11 states, "The facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilitates." It further states, "The training will cover interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action of prosecutorial referral, and information about effective cross-agency coordination in the investigation process." The training curriculum, (PREA) Investigating Sexual Abuse in Confinement Setting, was provided on-site through the National Institute of Corrections (NIC) and includes items such as: interviewing victims of sexual abuse; collection of physical evidence; Miranda and Garrity warnings; and the unique issues involved in sexual abuse investigations in a confinement setting. This training covers the unique nature of investigating sexual abuse in confinement; the techniques for interviewing sexual abuse victims; the proper uses of Miranda and Garrity warnings; the proper techniques for the collection of physical evidence; understanding best practices for reaching investigative conclusions; information about effective cross-agency coordination in the investigation process; and describing the level of evidence needed to substantiate both administrative and criminal findings. The Auditor determined the training curriculum meets the standard's requirements in all material ways.

The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement.

RCC has a pool of six investigators who have received specialized training for conducting sexual abuse investigations. A review of the investigators training certificates confirmed compliance. The Auditor reviewed the one investigative file and determined the investigator was trained as required by the standard. During the interview of the investigator who conducted the single investigation on file, he further verified that he received the training and was knowledgeable of the requirements needed to conduct sexual abuse investigations within a confinement setting.

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

(c): Policy 2.11 dictates that "all full and part-time Qualified Health Care Professionals and Qualified Mental Health Professionals, who work in the facility, shall receive specialized medical training on how to detect and assess signs of sexual abuse, how to preserve evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, how and to whom to report allegations of sexual abuse, and how to preserve physical evidence of sexual abuse." Interviews with the facility HSA confirmed that medical staff is required to receive the training and described the training as required in subpart (a) of the standard. Five certificates were presented for medical staff. The interviews with the Training Supervisor, and HSA, and review of training records for medical staff confirmed medical staff currently working at RCC have received the required training (PREA Medical and Mental Health Specialty Training – (E-Learning)). The Lead Auditor reviewed the training curriculum and confirmed that the PREA Medical and stated Mental Health Specialty Training covered all requirements of the standard. The Lead Auditor also confirmed by review of Policy 2.11 that the agency has reviewed and approved the policy.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): Policy 2.11 states, "All detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexual abusive behavior and shall be housed to prevent sexual abuse or assault, to assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger." The PSA Compliance Manager interview indicated that due to the low custody level of RCC, ICE screens out sexual predators and if any arrived, they would be relocated to a more appropriate facility. Policy 2.11 further states, "Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility and any detainees considered at risk for victimization, or of being a sexual predator by medical or mental health interviews would be considered for separation." The screening process involves the use of the Risk Classification Assessment (RCA) by Classification staff and the Sexual Abuse Screening Tool (Form 14-2B-DHS) by the medical staff. The RCA, in conjunction with the screening tool, takes into account

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 been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as LGBTI or gender nonconforming, whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as having previously experienced sexual victimization, and the detainee's own concerns about his or her physical safety. Classification staff further indicated that most detainees are assessed within four to five hours of their arrival for potential risk of sexual victimization or sexually abusive behavior. The APM reviewed 10 detainee medical files and determined the files contained the Sexual Abuse Screening Tool. In addition, the APM reviewed the same 10 detainee's detention files and confirmed the RCA was available for review, but the Sexual Abuse Screening Tool was not included in the detainee file. During the on-site visit of the facility, the medical intake staff provided the APM, and Lead Auditor, with copies of the PREA questions located on the Sexual Abuse Screening Tool asked during medical intake. The questions are available in 17 different languages, including Nepali, Gujarati, Chinese, Punjabi, Hindi, Spanish, Russian, Urdu, Bangla, Vietnamese, Tamil, Korean, Portuguese, Turkish, Persian, Armenian, and Romanian. Medical intake staff were interviewed and stated that when a detainee arrives speaking one of these languages, they are provided the questions to read and answer. They further stated that if the detainee didn't speak one of these languages, they were provided with the use of a translator via Language Line Services or google translation services.

(e): Policy 2.11 requires that "each detainee's risk of victimization or abusiveness is reassessed between sixty (60) and ninety (90) days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." Although the DHS PREA Standards only require a reassessment between 60 and 90 days from the date of the initial assessment, the APM's interview with the Classification Supervisor confirmed the facility is reassessing a detainee's risk level as required by the standard; however, the facility does not reassess a detainee after an allegation of sexual abuse or when additional information is obtained as required per the DHS PREA Standards or facility policy. The APM reviewed the single sexual abuse investigation which did not include a reassessment at any point after the incident. The APM also reviewed 10 detainee files. The files that required a reassessment were compliant with the 60- and 90-day requirement.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. The APM's review of the single sexual abuse investigation file confirmed that a reassessment following the alleged incident of sexual abuse was in fact not completed. To become compliant the facility must provide, if available, a sample of one or more sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse. In addition, a detailed policy and protocol must be provided, and the facility must submit documentation that both classification staff and investigators have received training regarding the requirement to complete the reassessment following an allegation of sexual abuse and when additional information is obtained.

(f): Policy 2.11 states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information, in response to questions asked during the intake process." Interviews with the PREA Compliance Manager, Intake staff, and Classification Supervisor indicated detainees are not disciplined for refusing to answer, or for not disclosing complete information, in response to questions asked pursuant to the standard.

(g): Policy 2.11 requires the "facility 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 LaSalle Corporate employee handbook, signed and receipted for by RCC employees, makes clear that "any provision of personal data is prohibited outside operational requirements." Interviews with the PSA Compliance Manager, Intake staff, the HSA, and Classification Supervisor confirmed that appropriate controls on the dissemination within the facility of the information obtained during the intake process are in place.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Policy 2.11 requires that "the facility use the information obtained through the Sexual Risk Screening Tool at initial screening when considering detainee housing, recreation, voluntary work programs and other activities." In review of 10 detainee files, the APM determined that the facility is not utilizing the data collected from the Sexual Abuse Screening Tool, completed by medical intake staff, to determine initial housing, recreation, work, and other activity decisions. Interviews with the HSA, classification, and security intake staff further confirmed the facility was not using all the information obtained as part of the risk assessment in 115.41, as required by the standard. According to the HSA, medical staff would only share the information if they determined other staff need to know based on their assessment of the detainee's responses to the risk screening.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41. The facility medical staff do not share information received during their portion of risk assessment process unless they determine the detainee is at risk or could be a danger to others. A review of 10 detainee and medical files, and interviews with classification and medical staff, confirms that this information is not always shared. In addition, should the information be shared, it is done via telephone and not documented. During interviews with the classification staff, security intake staff, and medical staff it was determined that the facility is utilizing information obtained in the RCA. To become compliant, the Sexual Abuse Screening Tool completed by medical staff needs to be shared with classification, and other necessary staff, so that proper housing, recreation, volunteer programming and other activities can be properly assessed. In addition, all classification, security intake, and medical staff should be trained in the proper use of the Sexual Abuse Screening Tool when determining the elements of the standard.

(b) : Policy 2.11 states, "In making assessments and housing decisions for transgender or intersex detainees, the facility will consider the detainee's gender and self-identification, and assessment of the effects of placement on the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment." Policy 2.11 further indicates, "Transgender and intersex detainees shall be reassessed at least twice a year to determine whether any threats to safety were experienced by the detainee." Interviews with Classification staff indicated that a medical and mental health professional would be consulted on a case-by-case basis, to determine whether the placement of transgender detainees would present management or security concerns; however, the Classification staff interviews confirmed they lacked knowledge when it came to housing transgender detainees. In addition, during the APM's interviews with the classification staff, the staff were unaware of the reassessment requirements for transgender detainees. The Lead Auditor had planned to interview transgender detainees during the on-site audit; however, there were no transgender detainees housed at the facility during the visit.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. During interviews with medical and classification staff, it was confirmed that staff are not knowledgeable regarding how to properly house and provide access to transgender and intersex detainees. To become compliant, the classification and medical staff need to be trained on the requirements to house, provide program access, and reassess transgender or intersex detainees. In addition, if available, the facility must submit the detainee and medical files of any transgender or intersex detainees housed at RCC during the CAP period.

(c) : Policy 2.11 states, "That when operationally feasible, transgender and intersex individuals shall be given an opportunity to shower separately from other detainees." Interviews with intake staff, the Classification Supervisor, and security line staff confirmed that transgender, or intersex, detainees are allowed to shower separately from other detainees.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c)(d)(e): Policy 2.11 prohibits the use of administrative segregation to protect detainees at high risk for sexual abuse and assault except in those instances where reasonable efforts have been made to provide appropriate housing. The policy further states, "such detainees shall be assigned to Administrative Segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of thirty (30) days" and "the facility will consult with the ICE FOD to determine if a less restrictive housing or custodial option is appropriate and available or whether transfer may be appropriate to a hospital or another facility where the detainee can be housed in general population or in an environment better suited to the needs of the detainee." Policy 2.11 further dictates, "If segregated housing is warranted, the facility will take the following actions: a supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted; a supervisory staff member will conduct an identical review after the detainee has spent 7 days in administrative segregation, and weekly after for the first 30 days, and every 10 days thereafter." The Warden indicated to the Lead Auditor that policy 2.11 was reviewed and approved by ICE. He stated that any detainee placements in segregation must be reported to the ICE FOD within 72 hours and if appropriate custodial options are not available at the facility, the facility will consult with the ICE FOD to determine if ICE can provide additional assistance. He also confirmed that should a detainee be placed in administrative segregation for protective custody, they would be provided access to programs, visitation, counsel, and other services available to the general population detainees to the extent possible. The Segregation Supervisor also indicated detainees would be provided access to programs, visitation, counsel, and other services available to the general population or document the reason it was not provided. The Lead Auditor confirmed through interviews, documentation submitted with the PAQ, and observation during the on-site visit that no detainees identified as a risk for sexual abuse and assault were placed in segregation for protection during the audit period.

§115.51 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): The Agency has provided a written directive, Policy 11087.1, section 4.10, page 11, which states in part that; "the FOD shall ensure that detainees are provided instructions on how they can privately report incidents of sexual abuse, retaliation for reporting sexual abuse, or violations of responsibilities that may have contributed to such incidents to ERO personnel. The FOD shall also implement procedures for ERO personnel to accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports." Finally, "the FOD shall ensure that detainees are provided with instructions on how they can contact the DHS/Office of the Inspector General (OIG) or as appropriate, another public or private entity which is able to receive and immediately forward detainee reports of sexual abuse to agency officials. Also, to confidentially and if desired, anonymously, report these incidents." In addition, policy 2.11 encourages detainees "to immediately report pressure, threats, or incidents of sexual abuse and assault, as well as possible retaliation by other detainees or employees for reporting sexual abuse and staff neglect, or violation of responsibilities that may have contributed to such incidents." Policy 2.11 outlines procedures for "staff to accept reports made verbally, in writing, anonymously, and from third parties, to promptly document any verbal reports, and requires the facility to provide instructions on how detainees may contact their consular official, the DHS OIG, and the ICE Detention and Reporting Information Line (DRIL) Hotline." Policy 2.11 further dictates that "the reporting will be confidential, and if desired, anonymous." Interviews with random detainees indicated that the majority are aware of the processes in place to report incidents of sexual misconduct, e.g., report to a staff member, file a grievance, place a phone call, contact their consular official, the DHS OIG or, as appropriate, another designated office to anonymously report. During intake, detainee's sign that they received a copy of both the RCC facility handbook

and the ICE National Detainee Handbook. During the on-site visit, the Auditors were able to view copies of both handbooks provided by the facility. Detainees received the handbooks in a language that they could understand, either provided by the facility or downloaded through the ICE website. If a detainee needs access to the facility handbook in a language not available at the facility, the Orientation Lt. utilizes google translation services to provide the detainee with a copy of the facility handbook in his preferred language. Handbooks include the process for detainees to report allegations of sexual misconduct including placing anonymous calls to the DHS OIG Hotline number and to the non-anonymous DRIL.

(c): Policy 2.11 requires "staff to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible and that staff shall promptly document any verbal reports." Staff are also advised in the LaSalle Corrections PREA policy that they may make reports in writing to the Warden or to the national #800 hotline number; this policy is part of RCC training of new employees and is receipted for during training. Each of the 10 random staff interviewed confirmed they must immediately report any allegation they become aware of; however, nearly every line staff interviewed were unaware of their requirement to document reporting by putting in writing any allegation verbally received. The Lead Investigator, during an interview, indicated that he normally writes the report immediately upon being notified orally by staff; however, this does not meet the standard's requirements. A review of the RCC handbook confirmed that the handbook Page 25, section 3, Reporting Sexual Assault/Abuse states, "If you become a victim of sexual assault/abuse, you should report it immediately to staff;" and that it includes the ICE PREA pamphlet outlining all ways a detainee can report an incident of sexual abuse as required by the standard.

Does Not Meet (c): The facility does not meet sub section (c) of the standard. According to interviews with line staff, they are unaware of their requirement to promptly document any verbal allegations of sexual abuse. To become compliant, the facility must offer refresher training to all line staff in their requirement to document, in writing, all reported allegations of sexual abuse.

Recommendation: The Lead Auditor recommends that the facility update Page 25, Section 3 Reporting Sexual Assault Abuse of the RCC handbook to include all ways a detainee can report an incident of sexual abuse.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f): Policy 2.11 states, "Detainees will be permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. To prepare a grievance a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representative. The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility shall issue a decision on the grievance within five (5) days of receipt and shall respond to an appeal of the grievance decision within thirty (30) days. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process." The Grievance Supervisor confirmed her office accepts, as a grievance, any allegation of sexual abuse and refers it immediately to the PSA Compliance Manager for investigation. She stated that should the detainee appeal a sexual abuse grievance she is aware of the requirement to decide on the grievance appeal within 30 days and that she does not impose a time limit on when a detainee may submit a grievance regarding the allegation of sexual abuse regardless of when it occurs and would ensure medical emergencies are referred to the medical department immediately. The Grievance Supervisor also indicated that her office had not received a formal grievance filed by a detainee involving an allegation related to sexual abuse during the audit period. Documentation submitted with the PAQ further confirmed no grievances relating to an allegation of sexual abuse were filed within the audit period. Grievance boxes are located throughout the facility to enhance detainee confidentiality. Staff indicated, during informal interviews, that the box contents are picked up daily.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d): Policy 2.11 requires "the facility develop an agreement with community service providers that provide legal advocacy and confidential emotional support for immigrant victims of crimes. In addition, as requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews." Documentation submitted with the PAQ confirms RCC has an MOU with Winn to provide support in areas of crisis intervention, counseling, and support during the investigation and prosecution. The most recent MOU was entered into during October 2021 and is continuous unless one of the parties gives a 30-day notice of intent to terminate the agreement. During the on-site visit, it was discovered that RCC did not have posted information regarding Winn in the facility; however, the RCC posted details in various languages on how to contact Winn on the last day of the onsite audit. The WINN information will be in all languages that the handbooks are in. The posted signage included the Winn address and telephone number, and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The facility also posted signage advising detainees that RCC reserves the right to monitor and record conversations on any telephone located within the institution. A review of the facility handbook also contained information regarding the existence of Winn; however, it did not contain their address, phone number, or the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The Lead Auditor confirmed during the detainee interviews that the majority were aware of their ability to receive confidential emotional support; however, they were not clear as to how to contact Winn. In an

interview with the PSA Compliance Manager, he indicated that the information will be included in the next revision of the RCC handbook.

Recommendation: It is recommended that the facility add the information regarding how to contact Winn to the facility handbook prior to the conclusion of the CAP period.

§115.54 - Third-party reporting.

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

Notes:

Policy 2.11 requires the facility "to establish a method to receive third-party reports of sexual abuse and shall post this information on the facility PREA link found on their website." During the APM's review of the RCC website, it was determined that the website navigates to the LDC website www.doc.louisiana.gov. The Lead Auditor reviewed the ICE website, www.ice.gov/prea. Both websites provide the public with multiple ways to report including third party reporting; however, the PREA information located on the LDC website is difficult to navigate to. Once there, the LDC website does provide guidance on methods to use to report to LDC as well as the national sexual assault hotline and states that every allegation will be investigated. In addition, although a review of the RCC handbook confirmed that the handbook Page 25, section 3 Reporting Sexual Assault/Abuse states, "If you become a victim of sexual assault/abuse, you should report it immediately to staff;", it also includes the ICE PREA Sexual Assault Awareness pamphlet outlining all ways a detainee can report an incident of sexual abuse, including how to report through a third party, as required by the standard.

Recommendation: The Lead Auditor recommends that the facility provide the PREA information on the website in a more direct manner so that it is easily navigated to by the public. In addition, the Lead Auditor recommends the facility update Page 25, Section 3 Reporting Sexual Assault Abuse of the RCC handbook to include all ways a detainee can report an incident of sexual abuse, even though it is transcribed into a language of the detainee's preference during the orientation process, thus enabling the detainee to also have access to this information and provide it to a third-party if need be.

§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): Policy 2.11 states, that the facility shall ensure that staff are trained on appropriate reporting procedures including a method to which staff can report outside the chain of command." During the Lead Auditor's interview with the Warden, he indicated that staff are advised in the LaSalle Corrections PREA policy that they may make reports in writing to the Warden or to the national #800 hotline number. He further stated that this policy is part of RCC training of new employees and is receipted for during training. The APM and Lead Auditor interviewed 12 random staff members, and each confirmed their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Staff was also aware of their ability to write directly to the Warden if it became necessary or make a report to the national #800 hotline number. Staff interviewed further indicated reporting obligations and maintaining confidentiality are presented in the annual PREA training they receive.

(b)(c): Policy 2.11 requires "all employees to immediately report: any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility in accordance with this policy, whether or not the area is under LaSalle's management authority. The policy spells out that the prohibition against retaliation against detainees or employees who have reported such an incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, policy 2.11 requires staff "not reveal any information related to a sexual abuse to anyone other than to the extent necessary, and as specified to make treatment, investigation, and other security and management decisions." Interviews with 12 random staff confirmed that they are aware of their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor and that information they become aware of is to remain confidential, except when disclosing to a supervisor or during the investigation to an investigator.

(d): Policy 2.11 requires "if the alleged victim is under the age of 18 or considered a vulnerable adult under a state or local vulnerable person's statute, the allegation shall be reported to the designated state or local services agency under applicable mandatory reporting laws." The Warden confirmed that, although it has not yet happened at RCC, if an alleged victim was designated as a vulnerable adult, he would be the person responsible for the necessary reporting and would contact the Louisiana Adult Protective Services where he is mandated to report the sexual abuse allegation. As previously noted, RCC is an adult male facility and does not accept juveniles.

§115.62 - Protection duties.

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

Notes:

Policy 2.11 requires that "when staff become aware a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee." The 12 random line staff interviewed confirmed if they become aware a detainee is at substantial risk of sexual abuse, their first response would be the safety of the detainee at risk. Their first course of action would be to seek out the detainee, isolate him, and notify their supervisor. The Warden, in his interview with the Lead Auditor, confirmed detainee safety would be his paramount concern. He confirmed his options would depend on the situation, but he would make sure the detainee is placed in the least restrictive housing available and would immediately ensure an investigation was conducted. In a review

of the single investigative file, the Lead Auditor determined the facility took the appropriate action required to protect the detainee victim.

§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): Policy 2.11 requires "when facility staff becomes aware of any allegation of sexual abuse that took place while the alleged victim was at another facility, the facility is to contact the facility head or appropriate office of the facility where the alleged abuse took place as soon as possible, but no later than 72 hours after receiving the allegation information. All such contacts and notifications shall be documented on the 5-1 B Notice to Administration (NTA)." Out of the 10 detainee files reviewed, the APM did not detect any allegations of sexual abuse at another facility that were made during the PREA risk screening. In addition, the facility PREA Compliance Manager interview indicated there had been no occurrences where a detainee, transferred from another facility, reported an incident of sexual abuse.

(d): Policy 2.11 requires, "If an allegation is received from another facility, alleging to have occurred at RCC, the facility must ensure the allegation is investigated." The Warden confirmed that, as with any allegation of sexual assault, he would immediately report the alleged incident to the FOD, the PREA Compliance Manager, and the facility lead investigator, who reports the allegation to the CPSO. The Warden further stated, he would also ensure that the facility investigates the allegation as required by policy.

§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): Policy 2.11 requires "The first security staff member to respond to the report, or his or her supervisor, shall ensure that the alleged victim and perpetrator are separated." In addition, policy 2.11 requires that "the responder shall, to the greatest extent possible, preserve and protect the crime scene until appropriate steps can be taken to collect evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall, request the alleged victim and abuser do not to take any actions that could destroy physical evidence" and "if the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." The 12 random security staff interviewed detailed their responsibilities as required under subpart (a) of this standard. The staff also carry a small card outlining their specific responsibilities as required by the standard. Staff randomly interviewed confirmed if a detainee reported an allegation to them, they would request the detainee victim not take any actions that could destroy physical evidence and would contact the closest security staff member. A review of the single investigation file indicated that the first staff responder acted per the requirements of the standard. According to documentation submitted with the PAQ, and the interview with the PREA Compliance Manager, there have not been any non-security responder occasions in the past 12 months.

§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): Policy 2.11 establishes a First Responder and Coordinated Response plan. Outlined in policy 2.11, "is RCCs' institutional plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to any incident of sexual abuse." First Responder cards were issued to all staff during 2019 and 2020 to enhance compliance in incident response. The policy provides a Sexual Abuse Incident Check Sheet, that is completed after an alleged incident, documenting whether the policy and plan was followed by staff. The Auditor interviewed the PSA Compliance Manager and the facility lead investigator who described their responsibilities when responding to incidents of sexual abuse.

(c)(d): Policy 2.11 requires, "If a victim of sexual abuse is transferred between any types of facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." Such a transfer did not occur in the last 12 months. In a memo submitted by RCC with the PAQ, the Warden noted that "The transfer of detainees between RCC and other facilities is coordinated through ICE ERO staff. To ensure appropriate information is transmitted to the receiving facility, including any involvement PREA incident, ERO staff include this information in the data (case comment) in the Enforce Alien Removal Module (EARM)." This practice was confirmed by the Warden during his interview.

§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:

Policy 2.11 requires "any staff, contractor, or volunteer suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of an investigation." The Warden confirmed he would remove anyone suspected of sexual abuse from the facility and from contact with any detainee, and they would not to be returned to duty until the outcome is determined by ICE OPR. A review of the single investigation file confirmed that the staff member was separated from the detainee making the allegation.

§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): Policy 2.11 "prohibits staff, contractors, and volunteers, and other detainees, from retaliating against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in

sexual activity as a result of force, coercion, threats, or fear of force. For at least 90 days following any report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews, or reassignments of staff. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." Policy 2.11 also "designates the PSA Compliance Manager to ensure the designated staff conducts retaliation monitoring, following a report of sexual abuse, to protect against potential retaliation against detainees or employees." Interviews with PSA Compliance Manager, and the facility Lead Investigator, confirmed that the facility monitors both staff and detainee retaliation and that each monitoring responsibility is assigned to appropriate staff at the time an allegation of sexual abuse is made. In addition, the facility Lead Investigator advised that there were no instances where staff retaliation monitoring was needed. The classification staff monitors detainee retaliation. The facility Lead Investigator confirmed the monitoring includes periodic status checks, at least monthly, of the detainee and review of relevant documentation, including any disciplinary reports and housing or program changes. The facility Lead Investigator further indicated that monitoring for both staff and detainees will continue beyond 90 days if the initial monitoring indicates a continuing need and that any instances of staff and/or detainees' retaliation would be brought to the attention of the PSA Compliance Manager who would report it to the Warden. A review of the single investigation file confirmed monitoring was conducted on the alleged detainee victim until his release about 2 months later. There were zero monitoring requests initiated for staff during the audit period.

§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): Policy 2.11 requires "the facility take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible." The Warden confirmed that he would notify the ICE FOD whenever a detainee victim has been held in administrative segregation. The Lead Auditor confirmed that no detainees were housed in protective custody due to their own request although they can request such protection if they choose. They can also request from the Major to terminate protective custody at any time.

(b)(c)(d): Policy 2.11 requires "a detainee victim who is in protective custody after having been subjected to sexual abuse not be held longer than five (5) days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee and that the detainee victim will not be returned to the general population until completion of a re-assessment taking into consideration any increased vulnerability of the detainee as a result from the sexual abuse." The policy further ensures "RCC shall notify the appropriate ICE Field Office Director (FOD) whenever a detainee victim has been held in administrative segregation for seventy-two (72) hours." The Warden confirmed that he would house a detainee victim of sexual abuse in the least restrictive housing option possible. There were no detainees placed in protective custody following an incident of sexual abuse; and therefore, there were no detainee reassessments to review prior to placement in general population.

§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): Policy 2.11 states, "Where sexual abuse is alleged, The Facility shall use investigators who are specially trained, qualified investigators in sexual abuse investigations and they must be prompt, thorough, objective and fair." The facility has a pool of six investigators. Documentation submitted to the Lead Auditor confirmed that all six investigators are specially trained. The facility Lead Investigator confirmed in an interview that all investigations into sexual abuse are prompt, objective, and thorough. A review of the one investigation file confirmed that the investigator was trained as required and that the investigation was prompt, thorough and objective.

(b): Policy 2.11 requires, "Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity." The facility Lead Investigator confirmed in an interview that an administrative investigation would be conducted on all allegations of sexual abuse after consultation with the investigative office within DHS and the Sheriff's Office. A review of the one investigation file confirmed all elements of subsection (b) of the standard had been met.

(c): Policy 2.11 states, "Administrative investigations include: preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data: interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; Retention of all reports and referrals of allegations for as long as the alleged abuser is detained or employed by the agency or facility, plus five (5) years; and Coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." Interviews with the PSA Compliance Manager, and Warden, confirmed that investigative files are retained in accordance with the standard and that an administrative investigation would

be conducted on all allegations of sexual abuse after consultation with the investigative office within DHS and the CPSO. A review of the single investigative file confirmed that all elements of subsection (c) of the standard have been substantially met.

(e)(f): Policy 2.11 states, "The departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." Interviews with the Warden, PSA Compliance Manager, and Lead Investigator, confirmed an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. Per Policy 2.11, "When outside agencies conduct investigations of sexual abuse and assault, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." In the one case during the audit period, the CPSO did conduct their own investigation after referral from the facility. The PSA Compliance Manager and Lead Investigator both stated that the lead facility investigator maintained close cooperation with the CPSO Investigators. The PSA Compliance Manager also indicated a positive relationship with several key staff at the CPSO and that RCC received continuous updates on any perceived issues. The single investigative file reviewed noted several contacts for coordination with during the CPSO's investigation period.

§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:

Policy 2.11 requires that "when an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse and assault are substantiated and that "any sexual abuse administrative investigation in which the facility is the primary investigating entity, the facility shall utilize a preponderance of the evidence standard for determining whether sexual abuse has taken place." The Lead Auditor determined the single investigation was completed in accordance with the standard. The facility Lead Investigator, during an interview, verified that the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated.

§115.73 - Reporting to detainees.

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

Notes:

Policy 2.11 requires, "Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken." The policy further requires, "If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee." The facility Lead Investigator confirmed detainees are informed of investigation outcomes regardless of the entity that completes the investigation. Following the ICE final case status determination, the detainee is provided the decision in person by the facility investigator and provided a written response utilizing Form 14-2E Detainee Allegation Status Notification, which is signed and filed in the detainee's file. During the on-site audit, the APM, through the Team Lead confirmed compliance on detainee notification of the outcome of the single investigative file reviewed via the "PREA Audit: Notification of PREA Investigation Result to Detainee - ICE Facilities," which included a copy of the notification sent.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d): Policy 2.11 requires, "Employees be subject to disciplinary sanctions up to and including termination for staff violating LaSalle's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff that have engaged in, attempted, or threatened to engage in sexual abuse." Policy 2.11 further states that "it is subject to the review and approval of ICE" and "All terminations for violations of LaSalle sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the act was clearly not criminal, and any relevant licensing bodies, to the extent known." The interview with the Warden confirmed the facility's policies and procedures regarding disciplinary or adverse actions for staff were provided to the agency for review and approval. An interview with the Warden and PSA Compliance Manager confirmed staff are subject to discipline for violations of the department's sexual abuse policies and termination is the presumptive disciplinary sanction for a staff member who has engaged in sexual abuse. The Warden confirmed the facility Lead Investigator is responsible for reporting such incidents to the facility personnel investigator for follow through and that the facility would also follow the Federal Security Clearance Process, which determines denial or revocation of government security clearance. According to a memo from the Warden submitted with the PAQ, and on-site interviews with the Warden, PSA Compliance Manager, and facility Lead Investigator, RCC did not have any staff who violated sexual abuse policies during this audit period. Therefore, files demonstrating termination, resignation, or other disciplinary actions were not available for review.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c): RCC policy 2.11 is that "any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures; and shall consider whether to prohibit pending the outcome of an investigation further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault; but have violated other provisions within these standards. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. In addition, policy requires the facility report such incidents to the ICE FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." The Warden confirmed that any contractor or volunteer suspected of

perpetrating sexual abuse would be removed from all duties involving detainee contact, and that if the allegation was substantiated, the incident would be reported to the contractor's employer, who would have the responsibility of reporting the incident to licensing bodies, if applicable. The facility did not have any allegations involving any of the medical/mental health contractors or any volunteers during this audit period.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b): Policy 2.11 states, "In addition to the forms of sexual abuse and/or assault defined in the definition section of 2.11, all other sexual conduct - including consensual sexual conduct - between detainees is prohibited and subject to disciplinary sanctions. Detainees shall 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." Policy 2.11 further requires, "Sanctions be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories." Interviews with the facility Warden, and PSA Compliance Manager confirmed compliance with sections (a) and (b) of the standard.

(c): Policy 2.11 details the RCC disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure. The PSA Compliance Manager interview, and memorandum submitted with the PAQ, reported there has been no detainee disciplined for any sexual abuse allegation during the audit period.

(d): Policy 2.11 requires "If a detainee is mentally disabled or mentally ill but competent, the disciplinary process shall 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." The Warden confirmed that contributing factors in the case would become evident in the investigative process and that the mitigating factors would be discussed prior to a misconduct report being issued. The PSA Compliance Manager interview, and memorandum submitted with the PAQ, reported there has been no detainee disciplined for any sexual abuse allegation during the audit period.

(e): Policy 2.11 "prohibits a detainee from being disciplined for sexual conduct with an employee unless the employee did not consent to such contact." The Warden confirmed that there had been no incidents of sexual abuse with an employee during the audit period, and that if an incident occurred, the detainee would not be disciplined for sexual conduct with an employee unless that employee did not consent to such contact.

(f): Policy 2.11 requires, "A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The Lead Auditor interviewed both the Warden, and PSA Compliance Manager, regarding sanctions for detainees. Both confirmed a detainee would not be disciplined for making a good faith allegation of sexual abuse. A review of the single investigative file, in which the detainee withdrew his allegation, but was not disciplined, further confirmed compliance with this section of the 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:

(a)(b)(c): Policy 2.11 requires "if the risk screening in standard 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner. If the detainee is referred to medical, the detainee must be seen within two working days from the assessment. If the detainee is referred to mental health the follow-up must be no later than 72 hours from the assessment." Medical staff, during the interview, indicated that they would immediately consult with security intake staff and would refer the detainee to mental health for follow-up. The Mental Health counselor affirmed in the interview that if medical referred a case to her, she would interview them within less than 72 hours as required. The APM interviewed, and reviewed the mental health files of, two detainees who reported sexual victimization during the intake risk screening. Both detainees, and the file reviews, confirmed that they were seen by mental health within the required timeframe.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy 2.11 requires "Detainee victims of sexual abuse and assault shall be provided timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." Policy 2.11 further requires, "Emergency medical treatment be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The HSA interview confirmed that detainees receive medical/mental health services immediately upon an allegation being made in accordance with professional standards of care, at no charge, regardless of if the victim participates in the investigation. The Lead Auditor reviewed one investigative file and determined the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. Following the incident, the detainee stated he did not need medical services, and therefore, was not taken to medical for assessment.

Does Not Meet (a): The facility is not compliant with section (a) of the standard. The Lead Auditor reviewed one investigative file and determined the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. Following the incident, the detainee stated he did not need medical services, and therefore, was not taken to medical for assessment. However, the standard requires timely, unimpeded access to medical, where the refusal of services can be made directly to medical staff and documented in the detainee's medical file. To become compliant the facility must develop a protocol that requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. In addition, the staff must be trained on the new protocol and the training must be documented.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 2.11 requires, "The facility to offer a medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse or assault while in immigration detention." Policy 2.11 also requires, "The evaluation and treatment of the victim; including follow-up services, treatment plans, and, when necessary, referrals for continued care consistent with the community level of care" and "the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody." The medical staff interviews confirmed that detainee treatment is immediate, based on their professional opinion, and consistent with community level of care, including additional follow up if necessary. In addition, interviews with medical staff confirmed that referrals for continued care following a detainee's transfer to, placement in another facility, or their release from custody would be made. A review of the one investigation file confirmed that following an incident of sexual abuse the facility neglected to take the alleged victim to medical due to the detainee indicating he did not want to go, therefore, the detainee was not offered a medical evaluation and or treatment should medical staff deem treatment was appropriate.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed the single investigative file and determined that the detainee was not taken to medical for evaluation as required by subsection (a). To become compliant the facility must train all supervisory staff in the requirement to deliver all alleged victims of sexual abuse to the medical department for evaluation and treatment as appropriate. In addition, the facility will need to document, if available, adherence to the standard by submitting any investigative files from allegations that occurred during the CAP period.

(d): RCC does not house female detainees; therefore, subpart (d) does not apply.

(e)(f): Policy 2.11 requires, "Detainee victims of sexual abuse shall be offered tests for sexually transmitted infections as medically appropriate" and that "Medical treatment services be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." This policy was confirmed by an interview with the HSA. The review of the single investigative file confirmed that no detainee was sent to the outside hospital during the audit period. The facility HSA indicated in an interview that she was not sure that the facility could perform these blood tests, and that they would typically be performed upon transfer to the outside hospital.

(g): Policy 2.11 requires, RCC "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." Medical and Mental Health records submitted during the on-site audit confirmed that a detainee whose initial risk screening indicated he had a history of being an alleged abuser was afforded the opportunity to meet with both medical and mental health staff for evaluation.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b)(c): Policy 2.11 states, the facility administrator will ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation." Policy 2.11 further states, "The incident review team shall include representation from upper-level facility management and the facility SART with input from line supervisors, investigators, and medical or mental health practitioners. The review will consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. The RCC team consists of the Grievance Coordinator, PSA Compliance Manager, and the Major. During the Lead Auditor's interview with the PSA Compliance Manager, it was indicated that the review team uses a generic PREA standard checklist for incidents; however, a review form or template could not be produced. Policy 2.11 further dictates that "the review team will also consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or gender non-conforming identification, status; or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility shall implement the recommendations or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the FOD or his or her designee, for transmission to the ICE PSA Coordinator. The facility shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator" and that "the facility conducts an annual review of all investigative files, and resulting incident reviews, to assess and improve sexual abuse intervention, prevention and response efforts, including preparation of a negative report if the facility does not have any reports of sexual abuse during the reporting year." Interviews with the Warden, and PSA Compliance Manager, and a review of RCC's annual PREA report confirmed compliance. In addition, a review of the one investigation file confirmed that the facility conducted a review of the incident which was ultimately determined to be unfounded.

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

a): Policy 2.11 requires, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling be retained in accordance with Policy 1-15 Retention of Records." The Warden confirmed the facility maintains these documents in a secure filing area under the control of the PSA Compliance Manager and that access is only on a need-to-know basis. During the on-site visit, the APM noted that although the office was occupied, the file was not under lock and key during the on-site visit.

Recommendation: The Auditor recommends that the file cabinet that contains sexual abuse investigation files is locked at all times including when the room is occupied.

§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)(e)(i)(j): During all stages of the audit including the on-site visit, the Auditors were able to review all policies, memos, and other documents required to make assessments on PREA compliance. Interviews with detainees were conducted in private on-site and remained confidential. Interviews with the staff were conducted on-site. The Auditors observed the notification of audit posted throughout the facility. No detainee correspondence was received prior to the on-site visit.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	32
Number of standards not met:	8
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.

William Peck 1/24/2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) 2/7/2022
PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 2/7/2022
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:	William Peck	**Organization:**	Creative Corrections, LLC
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	901-378-(b)(6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	772-579-(b)(6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	New Orleans Field Office		
Field Office Director:	AFOD(b)(6), (b)(7)(C)		
ERO PREA Field Coordinator:	SDDO (b) (6), (b) (7)(C)		
Field Office HQ physical address:	1250 Poydras St. New Orleans, LA 70113		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	River Correctional Center		
Physical address:	26362 Hwy 15 Ferriday, LA 71334		
Mailing address: *(if different from above)*			
Telephone number:	318-757-0622		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	Steven Debellevue	**Title:**	Facility Warden
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	318-757-(b)(6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	318-757-(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 U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of River Correctional Center (RCC) was conducted on December 7 – December 9, 2021, by U. S. Department of Justice (DOJ) and DHS certified PREA auditor William Peck for Creative Corrections, LLC. The Auditor was provided guidance during the report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C) who also provided on-site guidance; both are DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The RCC is privately owned by LaSalle Corrections and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes detainees who are pending immigration review or deportation. The PREA Incorporation date was February 1, 2019. This was the first DHS PREA audit for RCC and included a review of the 12-month audit period from December 6, 2020, through December 6, 2021. RCC is in Ferriday, LA.

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

115.17 Hiring and promotion decisions

115.21 Evidence protocols and forensic medical examinations

115.22 Policies to ensure investigation of allegations and appropriate agency oversight

115.41 Assessment for risk of victimization and abusiveness

115.42 Use of assessment information

115.51 Detainee reporting

115.82 Access to emergency medical and mental health services

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

The facility's Corrective Action Period (CAP) began February 7, 2022 and ended August 6, 2022. The facility submitted documentation, through the Agency, for the CAP on March 3, 2022, through August 2, 2022. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on August 2, 2022. The review of this documentation confirmed that all eight standards are compliant in all material ways.

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.

§115.17 - Hiring and promotion decisions

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

Notes:

(a)(b)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. The ICE Personnel Security and Suitability Program policy outlines misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Policy 2.11 requires "the facility, to the extent permitted by law, to decline to hire or promote any individual, and decline to enlist the services of any contractor or volunteer, who may have contact with detainees who: has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse" and requires that "the individual directly responds to questions about misconduct on form "Self-Declaration of Sexual Abuse/Sexual Harassment." The signed Self-Declaration of Sexual Abuse/Sexual Harassment form is to be retained in the employee's personnel file." Additionally, the LaSalle Corporate employee handbook, and hiring documents, both require this continuing responsibility. RCC staff sign for receipt of this workbook and employee manual. The HR Director further noted that their HR policy states that "material omissions regarding conduct as outlined in subpart (a) of this standard, or giving false information, is grounds for termination or withdrawal of an offer for employment and that, unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer." During the on-site portion of the audit, the Lead Auditor reviewed nine randomly selected staff personnel files and determined that all files lacked the Self-Declaration of Sexual Abuse/Sexual Harassment form.

Does Not Meet (b): The facility does not meet section (b) of the standard. Although there is a policy in place, RCC has not initiated the practice as outlined in the policy and required by subsection (b) of the standard. To become compliant, the facility must initiate the process to require all staff members to disclose any such misconduct annually using the Self-Declaration of Sexual Abuse/Sexual Harassment as directed by Policy 2.11.

Corrective Action Taken (b): The facility submitted 102 examples of completed Self-Declaration of Sexual Abuse/Sexual Harassment forms which confirmed they have required staff disclose any sexual misconduct on an annual basis as required by subsection (b) of the standard. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsection (b) of the standard.

§115.21 - Evidence protocols and forensic medical examinations

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

Notes:

(a): Policy 2.11 requires sexual abuse investigations, "follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocols must be developmentally appropriate, be adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, 'A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,' or similarly comprehensive and authoritative protocols developed after 2011." In the Lead Auditor's interviews with the Warden, and Lead Investigator, it was confirmed that although the Lead Investigator appeared to be knowledgeable, a facility evidence protocol was not developed as required by the standard. The Agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, "when

a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE Enforcement and Removal Operations (ERO) Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of the Inspector General (OIG), OPR, or the local law enforcement agency, the ICE AFOD would assign an administrative investigation to be conducted."

Does Not Meet (a): The facility has not developed an evidence protocol; and therefore, is not compliant with subpart (a) of the standard. To become compliant, the facility must develop a protocol that maximizes usable physical evidence for administrative proceedings and criminal prosecutions. In addition, the facility must train all applicable staff regarding the newly established protocol.

Corrective Action Taken (a): The facility submitted a developed protocol for investigating PREA/SAAPI allegations. The Auditor reviewed the protocol submitted by the facility and determined it complies with the requirements of standard subsection (a). In addition, the facility submitted training documents confirming all applicable staff have been trained on the new protocol. Upon review of the submitted documentation, the Auditor finds the facility is now in compliance with subsection (a) of the standard.

(c): Policy 2.11 requires "victims of sexual abuse have access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate. A Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) shall perform such examinations where possible. If SAFEs or SANEs cannot be made available, other qualified medical practitioners can perform the examination. The investigating entity shall document its efforts to provide SAFEs or SANEs." According to the HSA, RCC does not perform forensic exams at the facility. Detainees needing this type of exam are sent to Trinity Medical Center based on RCC's MOU with Trinity, dated 3/10/2021. The agreement in the MOU is to provide emergency services, inpatient care, and a SANE for comprehensive care in sexual assault cases for facility detainees. The APM, and Lead Auditor, interviewed the facility HSA, and the mental health practitioner, both of whom confirmed detainees making an allegation would be sent to the hospital, if medically appropriate, and seen by a SANE practitioner. The HSA also confirmed detainee victims would never be charged for medical services related to victimization. The Lead Auditor's review of the single investigative file indicated that the detainee was not offered access to a forensic exam, should it have been appropriate, as he was not taken to medical by the supervisor as required, due to the alleged detainee victim indicating at the time of the incident that he did not require medical attention, even though transport to the medical department is a mandatory requirement. The Lead Auditor confirmed that not transporting the alleged detainee victim to the medical area was the result of staff not having an investigation protocol to follow if an alleged incident of sexual abuse should occur.

Does Not Meet (c): The facility does not meet subsection (c) of the standard. A review of the single sexual abuse investigation confirmed that facility staff did not take the detainee to medical as required by the standard; therefore, the detainee was not afforded access to a forensic exam should one have been appropriate. Although the detainee declined services to security, the detainee should have been escorted to medical to comply with the standard, and then declination of services given to medical staff, who could have appropriately documented the declination in the detainee's medical file. To become compliant, the facility must develop a protocol that requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. In addition, the staff must be trained on the new protocol and the training must be documented.

Corrective Action Taken (c): The facility submitted a developed protocol for investigating PREA/SAAPI allegations which requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. The Auditor reviewed the protocol for investigating PREA/SAAPI allegations submitted by the facility and determined it complies with the requirements of standard subsection (c). In addition, the facility submitted training documents to confirm applicable staff were trained on the new protocol. Upon review of the submitted documentation, the Auditor finds the facility is now in compliance with subsection (c) of the standard.

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

(a)(b)(d): The Agency has provided a written directive, Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility

administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (b) (6), (b) (7)(C) Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." LaSalle Corporate policy 2.11 requires that "the facility administrator ensures that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault." Policy 2.11 further requires that "all criminal investigations be referred to a law enforcement agency with legal authority to conduct criminal investigations and that administrative investigations shall be conducted by the facility after consultation with the appropriate investigative office within ICE/DHS, and the assigned criminal investigative entity." This understanding is outlined in the 9/8/2021 MOU with the Concordia Parish Sheriff's Office (CPSO). RCC does not, however, have an investigation protocol detailing the roles and responsibilities of both the facility and the investigating entity in performing sexual abuse investigations. According to the Warden, and the Lead Investigator, all investigations are reported to the JIC, entered the JIC Management System, and then assessed to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG and/or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor-on-detainee sexual abuse allegations. Once the investigation 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 investigation 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 in 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 Warden, and Lead Investigator, confirmed that every allegation of sexual abuse made must be investigated. The facility Lead Investigator confirmed in an interview that an administrative investigation is conducted on all allegations of sexual abuse after consultation with the investigative office within DHS and the CPSO. In addition, policy 2.11 dictates that "the facility shall retain reports of allegations in accordance with Policy 1-15 Retention of Records which states, "PREA records shall be retained for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five years." Interviews with the Warden, PSA Compliance Manager, and facility investigator confirmed compliance with the standards requirement to retain all reports and referrals of allegations of sexual abuse for at least five years.

Does Not Meet (a)(b)(d): The facility is not in compliance with subsections (a)(b)(d) of the standard that requires the facility establish a protocol to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority as required in subsection (a) of the standard. As the facility does not have a protocol, the requirements of subsections (b)(d) that require what is included in the protocol is also non-compliant. To become compliant, the facility must develop a protocol that includes all elements of subsections (b)(d) of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content.

Corrective Action Taken (a)(b)(d): The facility submitted a developed protocol for investigating PREA/SAAPI allegations that includes all elements of subsections (b) and (d) of the standard. In addition, RCC submitted training documents confirming all applicable staff were trained on the contents of the protocol. Upon review of the submitted documentation, the Auditor finds the facility is now compliance with subsections (a), (b), and (d) of the standard.

(c): During the APM's review of the RCC website, it was determined that the website navigates to the Louisiana Department of Corrections (LDC) website doc.louisiana.gov which contains the LDC protocol. The Lead Auditor also reviewed the ICE website, (https://www.ice.gov/prea). Both websites provide the public with expected investigative protocols; however, the PREA information on the LDC website is difficult to navigate to and is not specific to RCC.

Does Not Meet (c): The facility is not compliant with subsection (c) of the standard. The investigation protocol located on the LDC website is not specific to RCC. To become compliant, the facility must develop an investigation protocol and make it available to the public as required by the standard.

Corrective Action Taken (c): The facility submitted a link to the facility website, https://lasallecorrections.com/human-rights/. The Auditor reviewed the facility website and confirmed that it does not contain the RCC investigative protocol, however, it does contain valuable PREA information that includes the name and contact information for the facility PREA Investigator should the reader request additional information regarding the investigative protocol. As the website allows the

reader to seek, and receive, further information regarding the facilities investigative protocol by contacting the facility investigator, the Auditor finds the facility in substantial compliance with subsection (c) of the standard.

§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:

(e): Policy 2.11 requires that "each detainee's risk of victimization or abusiveness is reassessed between sixty (60) and ninety (90) days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." Although the DHS PREA Standards only require a reassessment between 60 and 90 days from the date of the initial assessment, the APM's interview with the Classification Supervisor confirmed the facility is reassessing a detainee's risk level as required by the standard; however, the facility does not reassess a detainee after an allegation of sexual abuse or when additional information is obtained as required per the DHS PREA Standards or facility policy. The APM reviewed the single sexual abuse investigation which did not include a reassessment at any point after the incident. The APM also reviewed 10 detainee files. The files that required a reassessment were compliant with the 60- and 90-day requirement.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. The APM's review of the single sexual abuse investigation file confirmed that a reassessment following the alleged incident of sexual abuse was in fact not completed. The APM's interview with the Classification Supervisor confirmed the facility is reassessing a detainee's risk level as required by the standard; however, the facility does not reassess a detainee after an allegation of sexual abuse or when additional information is obtained as required per the DHS PREA Standards or facility policy. To become compliant, the facility must provide, if available, a sample of one or more sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse. In addition, a detailed policy and protocol must be provided, and the facility must submit documentation that both classification staff and investigators have received training regarding the requirement to complete the reassessment following an allegation of sexual abuse and when additional information is obtained.

Corrective Action Taken (e): The facility provided a copy of policy 2.11 SAPPI which includes the requirement that the detainee will be reassessed following an incident of sexual abuse and when additional information is obtained. In addition, the facility provided documented training confirming applicable staff were trained on the updated policy. On July 27, 2022, the facility submitted a memo to the ERO Assistant Officer in Charge (AOIC) that stated, "The River Correctional Center did not receive any additional sexual abuse allegations during the Corrective Action Plan period." This statement was subsequently confirmed by the ERAU Team Lead via email. Therefore, based on the provided information, which included an accepted protocol for investigating PREA/SAAPI allegations, policy 2.11 SAPPI, that includes the requirement that the detainee be reassessed following an incident of sexual abuse and when additional information is obtained, and the documented staff training regarding the protocol, the Auditor finds the facility is now in substantial compliance with subsection (e) of the standard.

§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): Policy 2.11 requires that "the facility use the information obtained through the Sexual Risk Screening Tool at initial screening when considering detainee housing, recreation, voluntary work programs and other activities." In review of 10 detainee files, the APM determined that the facility is not utilizing the data collected from the Sexual Abuse Screening Tool, completed by medical intake staff, to determine initial housing, recreation, work, and other activity decisions. Interviews with the HSA, classification, and security intake staff further confirmed the facility was not using all the information obtained as part of the risk assessment in 115.41, as required by the standard. According to the HSA, medical staff would only share the information if they determined other staff need to know based on their assessment of the detainee's responses to the risk screening.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41. The facility medical staff do not share information received during their portion of risk assessment process unless they determine the detainee is at risk or could be a danger to others. A review of 10 detainee and medical files, and interviews with classification and medical staff, confirms that this information is not always shared. In addition, should the information be shared, it is done via telephone and not documented. During interviews with the classification staff, security intake staff, and medical staff it was determined that the facility is utilizing information obtained in the RCA. To become compliant, the Sexual Abuse Screening Tool completed by medical staff needs to be shared with classification, and other necessary staff, so that proper

housing, recreation, volunteer programming and other activities can be properly assessed. In addition, all classification, security intake, and medical staff should be trained in the proper use of the Sexual Abuse Screening Tool when determining the elements of the standard.

Corrective Action Taken (a): The facility provided 10 PREA "Screening Checklists – Possible Victim Factors" which confirmed the facility utilizes the Screening Tool when determining housing. In addition, the facility provided the Auditor with 10 detainee files that confirmed the updated "River Correctional Center – Potential PREA Form" was implemented and is now utilized by staff when determining recreation, volunteer programming and other activities. The facility also provided staff training records confirming applicable staff received documented training on the new procedure. Upon review of the submitted documentation, the Auditor finds the facility is now in compliance with subsection (a) of the standard.

(b): Policy 2.11 states, "In making assessments and housing decisions for transgender or intersex detainees, the facility will consider the detainee's gender and self-identification, and assessment of the effects of placement on the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment." Policy 2.11 further indicates, "Transgender and intersex detainees shall be reassessed at least twice a year to determine whether any threats to safety were experienced by the detainee." Interviews with Classification staff indicated that a medical and mental health professional would be consulted on a case-by-case basis, to determine whether the placement of transgender detainees would present management or security concerns; however, the Classification staff interviews confirmed they lacked knowledge when it came to housing transgender detainees. In addition, during the APM's interviews with the classification staff, the staff were unaware of the reassessment requirements for transgender detainees. The Lead Auditor had planned to interview transgender detainees during the on-site audit; however, there were no transgender detainees housed at the facility during the visit.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. During interviews with medical and classification staff, it was confirmed that staff are not knowledgeable regarding how to properly house and provide access to transgender and intersex detainees. Interviews with Classification staff indicated that a medical and mental health professional would be consulted on a case-by-case basis, to determine whether the placement of transgender detainees would present management or security concerns; however, the Classification staff interviews confirmed they lacked knowledge when it came to housing transgender detainees. In addition, during the APM's interviews with the classification staff, the staff were unaware of the reassessment requirements for transgender detainees. To become compliant, the classification and medical staff need to be trained on the requirements to house, provide program access, and reassess transgender or intersex detainees. In addition, if available, the facility must submit the detainee and medical files of any transgender or intersex detainees housed at RCC during the CAP period.

Corrective Action Taken (b): The facility submitted training records to confirm that all applicable staff were trained in the requirements to house, provide program access, and reassess transgender or intersex detainees as part of their PREA/SAAPI training. On August 2, 2022, the facility provided the Auditor with a memo to the AOIC that confirmed that the facility did not admit any transgender or intersex detainees during the CAP. Therefore, based on the provided information which included training records confirming all applicable staff were trained in the requirements to house, provides program access, and reassess transgender or intersex detainees as required by the standard, the Auditor finds the facility is now in substantial compliance with subsection (b) of the standard.

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

(c): Policy 2.11 requires "staff to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible and that staff shall promptly document any verbal reports." Staff are also advised in the LaSalle Corrections PREA policy that they may make reports in writing to the Warden or to the national #800 hotline number; this policy is part of RCC training of new employees and is receipted for during training. Each of the 10 random staff interviewed confirmed they must immediately report any allegation they become aware of; however, nearly every line staff interviewed were unaware of their requirement to document reporting by putting in writing any allegation verbally received. The Lead Investigator, during an interview, indicated that he normally writes the report immediately upon being notified orally by staff; however, this does not meet the standard's requirements. A review of the RCC handbook confirmed that the handbook Page 25, section 3, Reporting Sexual Assault/Abuse states, "If you become a victim of sexual assault/abuse, you should report it immediately to staff;" and that it includes the ICE PREA pamphlet outlining all ways a detainee can report an incident of sexual abuse as required by the standard.

Does Not Meet (c): The facility does not meet subsection (c) of the standard. According to interviews with line staff, they are unaware of their requirement to promptly document any verbal allegations of sexual abuse. To become compliant, the

facility must offer refresher training to all line staff in their requirement to document, in writing, all reported allegations of sexual abuse.

Corrective Action Taken (c): The facility submitted training documents to confirm that applicable staff received refresher training on the standard's requirement to document, in writing, all reported allegations of sexual abuse. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsection (c) of the 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:

(a)(b): Policy 2.11 requires "Detainee victims of sexual abuse and assault shall be provided timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." Policy 2.11 further requires, "Emergency medical treatment be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The HSA interview confirmed that detainees receive medical/mental health services immediately upon an allegation being made in accordance with professional standards of care, at no charge, regardless of if the victim participates in the investigation. The Lead Auditor reviewed one investigative file and determined the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. Following the incident, the detainee stated he did not need medical services, and therefore, was not taken to medical for assessment.

Does Not Meet (a): The facility is not compliant with section (a) of the standard. The Lead Auditor reviewed one investigative file and determined the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. Following the incident, the detainee stated he did not need medical services, and therefore, was not taken to medical for assessment. However, the standard requires timely, unimpeded access to medical, where the refusal of services can be made directly to medical staff and documented in the detainee's medical file. To become compliant the facility must develop a protocol that requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. In addition, the staff must be trained on the new protocol and the training must be documented.

Corrective Action Taken (a): The facility submitted a developed protocol for investigating PREA/SAAPI allegations that requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. In addition, the facility provided staff training records confirming all applicable staff were trained on the new protocol. On July 27, 2022, the facility submitted a memo to the AOIC that states, "The River Correctional Center did not receive any additional sexual abuse allegations during the Corrective Action Plan period." This statement was confirmed by the ERAU Team Lead. Therefore, based on the provided information which included an accepted protocol for investigating PREA/SAAPI allegations requiring staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse and the submitted documented staff training regarding the protocol, the Auditor finds that the facility is now in substantial compliance with subsection (a) of the 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:

(a)(b)(c): Policy 2.11 requires, "The facility to offer a medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse or assault while in immigration detention." Policy 2.11 also requires, "The evaluation and treatment of the victim; including follow-up services, treatment plans, and, when necessary, referrals for continued care consistent with the community level of care" and "the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody." The medical staff interviews confirmed that detainee treatment is immediate, based on their professional opinion, and consistent with community level of care, including additional follow up if necessary. In addition, interviews with medical staff confirmed that referrals for continued care following a detainee's transfer to, placement in another facility, or their release from custody would be made. A review of the one investigation file confirmed that following an incident of sexual abuse the facility neglected to take the alleged victim to medical due to the detainee indicating he did not want to go, therefore, the detainee was not offered a medical evaluation and or treatment should medical staff deem treatment was appropriate.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed the single investigative file and determined that the detainee was not taken to medical for evaluation as required by subsection (a).

To become compliant, the facility must train all supervisory staff in the requirement to deliver all alleged victims of sexual abuse to the medical department for evaluation and treatment as appropriate. In addition, the facility will need to document, if available, adherence to the standard by submitting any investigative files from allegations that occurred during the CAP period.

Corrective Action Taken (a): The facility submitted a developed protocol for investigating PREA/SAAPI allegations that requires staff to take an alleged victim of sexual assault to the medical department for evaluation and treatment as appropriate. In addition, the facility provided staff training records confirming all applicable staff were trained on the new protocol. On July 27, 2022, the facility submitted a memo to the AOIC that states, "The River Correctional Center did not receive any additional sexual abuse allegations during the Corrective Action Plan period." This statement was confirmed by the ERAU Team Lead. Therefore, based on the provided information which included an accepted protocol for investigating PREA/SAAPI allegations requiring staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse and the submitted documented staff training regarding the protocol, the Auditor finds that the facility is now in substantial compliance with subsection (a) of the standard.

§115.Choose an item.
Outcome: Choose an item.
Notes:

§115. Choose an item.
Outcome: Choose an item.
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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.

William Peck August 17, 2022
Auditor's Signature & Date

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

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