PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	5/4/2021	**To:**	5/5/2021
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Creations, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-381-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	San Antonio Field Office
Field Office Director:	Daniel Bible
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1777 NE Loop 410 Floor 15 San Antonio, TX, 78217
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	South Texas ICE Processing Center		
Physical address:	566 Veterans Drive - Pearsall, TX 78061		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	830-334-2939		
Facility type:	CDF		
PREA Incorporation Date:	9/25/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	830-334-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Compliance Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	830-334-(b) (6), (b) (7)(C)
Form Key:	29		
Revision Date:	02/24/2020		
Notes:	Click or tap here to enter text.		

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the South Texas ICE Processing Center (STIPC) was conducted on May 4-5 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt, a contractor with 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, (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR), and External Reviews and Analysis Unit (ERAU) during the audit report review process. The STIPC is privately owned by the GEO Group and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and houses male and female adult detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities detained at STIPC are from Mexico, Honduras, and Cuba. STIPC is located in Pearsall, Texas.

This is the second PREA audit for STIPC. The ICE PREA audit was originally scheduled for May 2020 and postponed due to the COVID-19 health pandemic. The audit was changed to a contingency audit. ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g. a health pandemic. The process is divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. During the Pre-Audit phase, the ERAU Team Lead contacts the facility to request submittal of facility documentation, completes a quality control review of the documentation, and uploads the documentation to SharePoint for the Auditor's review. As part of the initial document request, the Team Lead requests current rosters for detainees, staff, contractors, and volunteers, including any ICE staff assigned to the facility. Based on the size of the facility, the Auditor then selects the appropriate number of detainees, staff, volunteers, and contractors from the rosters to interview and supplemental documentation needed to confirm the facility's compliance with the PREA regulations. The second phase, Remote Interviews, consists of interviews (either through a virtual conference platform or conference line, the latter if the virtual platform is unavailable) with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers. The third phase, the On-site Audit, is not scheduled until the environment is safe for the ICE federal staff, facility staff, detainees, and Auditors. This phase mirrors a traditional PREA audit with a facility tour, observation of facility practices, and follow-up from the prior phases, as needed. Exit briefings occur at the end of Phase Two and Three, during which compliance issues identified and potential recommendations are discussed, if warranted. The facility's compliance is not fully determined until the completion of the on-site audit phase.

Full compliance was contingent upon the on-site review of observations of facility's operational practices during the facility tour, any additional documentation review, and interviews with staff and detainees and review of the Auditor's notes and information gathered during Phases One and Two of the contingency audit process to determine all subparts of the standard were appropriately handled per the standard's requirement. A second Auditor was utilized during Phase One and Two. Prior to Phase Three, the On-Site audit, the Auditor requested updated facility information and received additional documentation from the ERAU Team Lead and facility staff. The on-site audit consisted of a facility tour, additional interviews of staff and detainees, and review of follow-up documentation. The audit period was May 2019 to July 27, 2020.

Approximately four weeks prior to the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA is 2.1.1, Sexual Abuse and Assault Prevention and Intervention (SAAPI). All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Lead Auditor to the facility for the interviews with staff and detainees. The Lead Auditor also reviewed the facility's website, www.geogroup.com/PREA.

The STIPC consists of 21 dormitory style living units and 4 cell block housing units, for a total of 25 housing units. The facility has not housed female detainees since April 2020; however, designation of female dorms could likely change based on their need.

The facility utilizes trained investigators to complete all allegations of sexual abuse. There were 19 reported sexual abuse allegations during the audit period. Seventeen occurred at STIPC and two allegations reported occurred at other facilities. Of the 17 allegations occurring at the facility, 15 investigations were closed and two were actively being investigated by ICE OPR. Of the 17 Investigations, 4 were staff-on-detainee and 13 were detainee-on-detainee. Of the staff-on-detainee allegations, one was unfounded, one was unsubstantiated, and two remained open. Of the detainee-on-detainee allegations, ten were unsubstantiated and three unfounded. The Auditor conducted an in-depth review of eight randomly selected sexual abuse allegation files. All of the allegations were referred to ICE OPR. Each of the 17 allegations at STIPC were referred to the Pearsall Police Department. None were deemed criminal. Of the 15 completed allegations reviewed, 4 cases were unfounded, and 11 cases were unsubstantiated.

The entry briefing was conducted by the ERAU Team Lead at 8:00 a.m. on May 4, 2021. In attendance were:

(b) (6), (b) (7)(C) Facility Administrator, GEO
(b) (6), (b) (7)(C) Compliance Administrator, GEO
(b) (6), (b) (7)(C) Facility Investigator, GEO
(b) (6), (b) (7)(C) Deputy Administrator Administration, GEO
(b) (6), (b) (7)(C) Contracting Officer's Representative (COR), ICE/ERO
Lieutenant Commander, (LCDR) (b) (6), (b) (7)(C) Assistant Health Services Administrator (AHSA), ICE Health Service Corps (IHSC)
(b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
(b) (6), (b) (7)(C) Inspections and Compliance Specialist, DHS/ICE/OPR/ERAU
(b) (6), (b) (7)(C) Certified PREA Auditor, Creative Corrections
(b) (6), (b) (7)(C) SDDO, ICE/ERO

(b) (6), (b) (7)(C) Deputy Administrator, GEO

Brief introductions were made, and the Auditor provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Lead Auditor explained the audit process is designed to assess compliance through written policies and procedures and to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policies and procedures, observations made at the time of the facility tour, review of documentation, and the results of interviews with both staff and detainees.

The Auditor shared that he received no correspondence from any detainee before the contingency audit. The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific categories) including an alphabetic and housing listing of all detainees detained at the facility, lists of staff by duty position and shifts, and a list of volunteers/contractors on duty during the contingency audit.

The Auditors conducted 31 formal detainee interviews, randomly selected from the housing units throughout the facility. Twenty-three detainees interviewed were limited English proficient (LEP) and required the use of Language Services Associates (LSA), an interpretation service contracted through Creative Corrections. A total of 36 staff/contractors were formally interviewed using a conference line. Twelve line staff/contractors across each of the three shifts were randomly selected for interview. Additionally, specialized staff were interviewed including the Facility Administrator, Prevention of Sexual Assault (PSA) Compliance Manager, first line supervisors (3), medical and mental health staff (3), Administration/Human Resources staff, non-security volunteers/contractors (2), investigators (1), Training Administrator, Grievance Officer, Chief of Intake, Restricted Housing Unit (RHU) Supervisor, Classification Officer, Chaplain, SDDO, Deportation Officer, and intake staff (2).

On May 5, 2021 an exit briefing was held in the facility conference room. The Team Lead opened the briefing and then turned it over to the Auditor.

In attendance were:

(b) (6), (b) (7)(C) Facility Administrator, GEO
(b) (6), (b) (7)(C) Compliance Administrator, GEO
(b) (6), (b) (7)(C) Facility Investigator, GEO
(b) (6), (b) (7)(C) Deputy Administrator, GEO
(b) (6), (b) (7)(C) - Chief of Intake, GEO
(b) (6), (b) (7)(C) - COR, ICE/ERO
(b) (6), (b) (7)(C) Assistant Health Services Administrator (AHSA), IHSC
(b) (6), (b) (7)(C) SDDO, ICE/ERO
(b) (6), (b) (7)(C) Inspections and Compliance Specialist, DHS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), SDDO, ICE/ERO
(b) (6), (b) (7)(C) Deputy Administrator, GEO
(b) (6), (b) (7)(C) Deportation Officer, ICE/ERO
(b) (6), (b) (7)(C) Certified PREA Auditor, Creative Corrections

The Auditor spoke briefly about his observations. He noted how impressive the intake process was as it required each detainee to acknowledge by signature their intake risk assessment. The Auditor was able to give some preliminary findings but informed them that it was too early to determine the outcome. Detainees interviewed had a good understanding of PREA and knew what mechanisms are in place at STIPC to report incidents of sexual misconduct if needed. The Auditor thanked the GEO and ICE staff for their cooperation during the audit.

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: 2

§115.17 Hiring and promotion decisions
§115.31 Staff training

Number of Standards Not Applicable: 2

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

Number of Standards Met: 36

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§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
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of audits.

Number of Standards Not Met: 1
§115.41 Assessment for risk of victimization and abusiveness

PROVISIONS

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

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

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

Notes:

(c)(d): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 Sexual Abuse & Assault Prevention and Intervention Programs, which requires "STIPC to articulate and adhere to a standard of zero- tolerance for incidents of sexual abuse and/or assault that may occur in the facility. Detainees and staff shall be informed about the facility's sexual abuse or assault prevention and intervention program and the zero- tolerance policy. Employees are required to be trained in ways to identify and subsequently prevent sexually assaultive behavior among detainees housed at this facility." During the staff interviews, each staff person was aware and discussed the significant elements of the policy. Most of the random detainees interviewed were aware of their right to not be sexually abused or assaulted and how to report it. The facility provided documentation that the zero-tolerance policy was approved by the ICE ERO Officer in Charge (OIC). The PSA Compliance Manager indicated she reports directly to the Facility Administrator and verified she is the point of contact for the agency's PSA Coordinator. She also confirmed she has sufficient time and authority to oversee efforts for the facility to comply with the zero-tolerance policy. The position of PSA Compliance Manager is found on the organizational chart for STIPC with direct contact with the Facility Administrator.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "STIPC ensure it maintains sufficient supervision of detainees, including through appropriate staffing levels, and where applicable, video monitoring to protect detainees against sexual abuse. STIPC reviews their staffing guidelines at least annually utilizing attachment B (Annual PREA Facility Assessment)." The policy further requires, "the review to be submitted to the local PSA Compliance Manager and Corporate PREA Coordinator annually as determined by GEO's U.S. Corrections and Detention Division." The Facility Administrator confirmed that staffing levels for the supervision of the detainees are established prior to the contract agreement between all the aforementioned parties. He stated that staffing levels are based on direct supervision of the detainees taking into account: video monitoring equipment present at STIPC; generally accepted detention/correctional practices; any judicial findings of inadequacy; the physical plant; detainee population; findings of incidents of sexual abuse; any recommendations of sexual abuse incident reviews; and any other relevant factors. These considerations are the major elements of the annual staffing review as required in policy 2.1.1. The PSA Compliance Manager also detailed these elements during her interview and confirmed she participated in the last review conducted in September 2020. The Auditors were provided a copy of this document for review and approval, as well as post orders detailing supervision and security round responsibilities for assigned staff and supervisors. The Facility Administrator and each shift Watch Commander confirmed detainee supervision posts are never closed and unannounced rounds are made throughout the facility on each shift and documented.

(d): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires "STIPC supervisors to conduct frequent unannounced security inspections to identify and deter sexual abuse of detainees. Such inspections will be conducted no less than once per week for all shifts." Supervisor interviews indicated these rounds are made on each shift daily. The Auditor observed supervisor signatures in areas having logs where detainees have access. Rounds were documented for all shifts. This same policy also prohibits employees from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility. The interviews with the security line staff confirmed their knowledge of the policy of not notifying other staff about supervisory rounds being conducted.

Recommendation: The current policy states, "Such inspections will be conducted no less than once per week for all shifts." However, the standard requirement and the facility's current practice require unannounced rounds to be conducted on each shift daily. As such, the Auditor recommends the facility update their policy to reflect the current practice, which is consistent with the regulatory requirement.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

STIPC does not accept juveniles or family detainees. This was confirmed in the PAQ, during interviews conducted with the Facility Administrator, PSA Compliance Manager, and the personal observations by the Auditor while on-site.

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

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

Notes:

(b)(c)(d): The Auditor determined compliance with these subparts after a review of policy 2.1.1 that specifies "searches are necessary to ensure the safety of officers, civilians, and detainees; to detect and secure evidence of criminal activity; and to promote security, safety and related interests at STIPC." This policy further directs searches be performed in the following manner, "cross gender pat-down searches of male detainees are not to be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search or in exigent circumstances; cross-gender pat-down searches of female detainees are prohibited, absent exigent circumstances; and all cross-gender strip searches and cross-gender visual body cavity searches are prohibited except in exigent circumstances or when performed by medical practitioners. All cross-gender pat-down searches are to be documented on attachment G (Cross-Gender Pat-Search Log)." The security staff interviews also detailed for the Auditor the conditions under which a pat-search may be performed at STIPC. These conditions were the same requirements outlined in policy 2.1.1 and these subparts. The Auditors reviewed the PAQ and interviewed both the Facility Administrator and PSA Compliance Manager who confirmed STIPC had not conducted any cross-gender pat-searches during the audit period, but if they had, they would be documented as outlined in policy 2.1.1.

(e)(f): The Auditor determined compliance with these subparts after a review of policy 2.1.1 that "prohibits cross-gender strip searches and cross-gender visual body cavity searches except in exigent circumstances, including consideration of the officer safety or when performed by a medical practitioner." The policy further requires STIPC to document and justify when either type search is conducted. The Auditor interviewed both male and female random security staff from each shift and each indicated that their training on detainee searches is provided in pre-service and annually during in-service training. Both security and medical health care staff detailed for the Auditor the conditions under which a strip search and body cavity search may be performed at STIPC. According to their interviews, the facility staff can not conduct strip searches; if needed ICE Officers can conduct strip searches and medical staff would conduct cavity searches, if required. The PAQ and interviews with the Facility Administrator, medical staff and the PSA Compliance Manager indicated STIPC neither authorized nor conducted any strip or body cavity searches during the audit period.

(g): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires the facility to "implement policies and procedures that allow detainees to shower, change clothes, and perform bodily functions without employees of the opposite gender viewing them, absent exigent circumstances or instances when the viewing is incidental to routine cell checks or otherwise appropriate in connection with a medical examination or monitored bowel movement." This policy further requires "all employees of the opposite gender to announce their presence when entering housing units or any areas where detainees are likely to be showering, performing bodily functions, or changing clothes." During the interviews with random security and non-security staff, all confirmed their requirement to announce their presence every time they enter any area where detainees of the opposite gender may be showering, changing clothes, and performing bodily functions. The Auditors interviewed 31 random detainees and the majority confirmed staff of the opposite gender announce themselves prior to entering their living areas or areas where they may be showering, changing clothes or using the toilet. During the on-site visit the Auditor observed opposite gender announcements being made.

(h): STIPC is not a Family Residential Center; therefore, this subpart provision is not applicable.

(i)(j): The Auditor determined compliance with these subparts after a review of policy 2.1.1 that requires "security staff be trained to conduct cross-gender pat-down searches and searches of transgender and intersex detainees in a professional and respectful manner and in the least intrusive manner." The Auditors interviewed both male and female random security staff from each shift, 12 in total, with each indicating that training on detainee searches, to include cross-gender pat-down searches and searches of transgender and intersex detainees is provided in pre-service and annually during in-service training, for which they sign an acknowledgement indicating receipt of and understanding of the training. The policy also restricts searches or physical examinations of any detainee for the purpose of determining their genital status. If the detainee's genital status is unknown, it may be determined during conversations with the individual, by reviewing medical records, or by learning that information as part of a broader medical examination conducted in private by a medical practitioner. During the random security staff interviews, each confirmed their knowledge of the prohibition of searching any detainee to determine their genital status and their responsibility to perform all pat-down searches in a professional and respectful manner. The Auditor reviewed the training curriculum with the Training Administrator and found that the search training provided to staff meets subpart (j) training requirements. Also, the 12 security line staff interviewed confirmed their training on conducting searches of transgender and intersex detainees in a professional manner.

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

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

(a)(b): The Auditor determined compliance with these subparts after a review of policy 2.1.1 that requires "STIPC to ensure individuals who are LEP and those detainees with disabilities (including those who are deaf, hard of hearing, blind, or have low vision, intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and assault. The policy further requires STIPC to provide written materials to every detainee in formats or through methods that ensure effective communication with detainees with disabilities. The methods to ensure effective communication shall include, when necessary, access to in-person, telephonic, or video interpretive services that enable effective, accurate communication, and have an equal opportunity for each detainee to participate in and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and assault." According to three intake staff interviewed, each detainee arriving at STIPC receives the GEO STIPC Detainee Handbook, DHS-prescribed Sexual Abuse and Assault Awareness Information pamphlet, and the ICE National Detainee Handbook. The GEO STIPC Detainee Handbook is available in English and Spanish formats only. Although the DHS-prescribed Sexual Abuse and Assault Awareness Information pamphlet is available at STIPC in English only, it is available through ICE in 9 nine languages: English, Spanish, Arabic, Haitian Creole, French, Hindi, Portuguese, Punjab, and Chinese. The ICE National Detainee Handbook is available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). The intake staff interviews confirmed that when confronted with a detainee that may be hearing impaired or deaf, information is provided to them in writing or through use of the text telephone (TTY). Those who are blind or with limited sight are provided individualized service by the intake staff to include reading information to him or her if needed. For those detainees with intellectual deficiencies, the intake staff would refer the detainee to a supervisor, medical or mental health staff based on the detainee limitation (low cognitive skills, limited reading skills, etc.). LEP detainees are provided assistance by staff through interpretative services, either through available staff or Language Line Solutions, an interpretation service. Interviews with random staff and the Classification staff person indicated there are currently three videos that are required to be played daily. Three informational videos (STIPC Orientation, PREA, and Know your Rights) run continuously in the intake area and in each housing unit. The videos are in English and Spanish. The intake staff also indicated when written materials are not available in languages provided, staff utilize the language line interpretive services. The facility provided the Auditors with copies of logs of the interpretive services being utilized, which further noted the language as well. When completing a vulnerability assessment, if staff interpreters are not available for a specific language needed, a note section on the form indicates the type of interpretive services utilized. Although STIPC keeps logs for any use of this interpretive service which indicates date and time for use of service, they neither included what the service was specifically used for (risk assessment or orientation) nor the language used. Furthermore, during detainee interviews, 3 detainees, who did not speak one of the 11 prevalent languages, indicated they had not received this information in a language or format that they understood. The interview with the intake staff and PSA Compliance Manager confirmed that STIPC has a script it utilizes for detainees, via the language line, to obtain for languages not provided through the ICE National Handbook. The manuscript provided to the Auditor detailed prevention and intervention strategies, definitions of prohibited acts, how to report, prohibition about retaliation and information on treatment and counseling.

Recommendation: The facility should document when the interpretive service is used for orientation, risk screening, and reassessment processes and maintain a copy within the detainee's detention file, including when the manuscript is utilized.

(c): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires, "in matters relating to sexual abuse, STIPC to provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other

than another detainee, unless the detainee expresses a preference for a detainee interpreter, and the facility determines that such interpretation is appropriate and consistent with DHS policy. Any use of these interpreters under this type of circumstances shall be justified and fully documented in the written investigative report." The policy also, "prohibits the use of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser in matters relating to allegations of sexual abuse." During interviews with random security staff, each confirmed they were aware of the policy restrictions and use of interpreters. Five of the eight investigative case files involved non-English speaking detainees and the Auditor's review of the investigative files confirmed the detainee was provided interpreter services through the Assistant Administrator.

§115.17 - Hiring and promotion decisions.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(e)(f): The Auditor determined compliance with these subparts after a review of policy 2.1.1 that, " prohibits the facility from hiring, promoting or contracting with anyone who will have direct contact with detainees who has: engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility or other institution; been convicted of engaging in sexual activity facilitated by force, overt or implied threats of force, or coercion, if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity in confinement settings or in the community." Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0, requires anyone entering into or remaining in government service, employee, or contractor, undergo a thorough background examination for suitability and retention. The Division Chief of the OPR Personnel Security Unit (PSU), (b) (6), (b) (7)(C) informed Auditors who attended training in Arlington, Virginia in September 2018, that candidate suitability for all employment applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Applicants are questioned directly about any such previous misconduct both during their background check and during the job interview process and a positive response to any of those specific questions are grounds for unsuitability including material omissions or making false or misleading statements in the application. The interview with the STIPC Human Resources (HR) Manager confirmed the facility would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated this information is provided through GEO Corporate and stated the facility would request information from prior institutions where the prospective candidate was previously employed and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire.

(c)(d): The Auditor determined compliance with these subparts after a review of Federal Statute 731.105 that requires background reinvestigations be conducted on all staff and contractors who may have contact with detainees, every five years. The Division Chief of the OPR PSU confirmed that ICE conducts these background checks on contractors and staff. STIPC exceeds the standard requirement of the five-year updated background check by also having the Alverde County Sheriff Office conduct an annual background check through the National Crime Information Center (NCIC) on all staff, contractors, and volunteers. The Auditors reviewed the background investigations for four GEO and four ICE employees at STIPC and found each was current.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes))

Notes:

(a)(b): These subparts of the standard are currently not applicable based on the PAQ and the interview with the Facility Administrator confirming STIPC has not expanded or modified the existing facility or updated video monitoring equipment since the previous audit in 2017.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a): The Auditor determined compliance with this subpart of the standard based on review of policy 5.1.2-F, PREA Investigative Policy that requires "facilities that are responsible for investigating allegations of sexual abuse to follow uniform evidence protocols that maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocols shall be developmentally appropriate for juveniles where applicable and developed in coordination with DHS." The Facility Administrator confirmed and provided documentation supporting the policy was reviewed and approved by the OIC. The facility's Investigator confirmed she follows the evidence protocols provided in training and outlined in policy to ensure she obtains the physical evidence needed for her administrative investigations. PREA allegations may also be investigated through DHS Office of Inspector General (OIG). 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 sexual assault evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE 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 to or accepted by DHS OIG, OPR, or the local law enforcement agency, ERO would conduct an administrative investigation. The Auditors found, after the thorough review of eight investigative files, uniform evidence protocols were followed during the administrative investigations.

(b)(d): The Auditor determined compliance with these subparts of the standard after review of the Memorandum of Understanding (MOU) between the Methodist Healthcare System of San Antonio, Ltd, L.L.P. d/b/a Methodist Hospital (Methodist Specialty & Transplant Hospital campus) "MSTH" through its Sexual Assault Nurse Examiner (SANE) Program and the GEO Group, Inc. This document requires the hospital to provide medical forensic examinations for persons thirteen years of age or older making an allegation of sexual assault, and for the removal of physical evidence from any aged person suspected of having committed an act of sexual assault/abuse. The MOU also agrees to provide detainee victims of sexual abuse access to an outside victim advocate (Rape Crisis Center in San Antonio) for emotional support services. The MOU stipulates the MSTH will provide the alleged victim a forensic examination by a trained SANE. The interview with the coordinator of the forensic nurse examiners program at MSTH confirmed the hospital provides a forensic nurse examiner for all forensic examinations as well as a trained sexual assault advocate from the Rape Crisis Center.

(c): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires "if the alleged sexual abuse is reported or discovered within 96 hours of the incident, and if determined appropriate by the medical provider and/or investigator, the alleged victim

shall be transported to the designated off-site facility for the collection of forensic evidence by a SANE or Sexual Assault Forensic Examiner (SAFE) and medical treatment." The policy further requires "all services be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the allegation." The STIPC's medical department is managed and operated by IHSC Facility medical staff are prohibited by policy to participate in sexual assault forensic medical examinations or evidence gathering. The AHSA confirmed forensic examinations are conducted at the MSTH by a trained SANE through an MOU with no sunset date. The facility had no forensic examinations conducted during the audit period based on interviews with the PSA Compliance Manager, the AHSA, and review of the facility's PAQ.

(e): The facility provided documentation of a MOU request between STIPC and the Pearsall Police Department. The facility policy and MOU request requires the law enforcement department be contacted in every case of sexual abuse alleged at the facility. The MOU and interview with the Chief of Police confirmed their office is contacted upon every allegation of sexual abuse and would conduct a criminal investigation if it was determined the incident was criminal in nature. He also confirmed, that although not specifically stated in the MOU, his department would comply with subparts (a) through (d) of this standard. During the review of investigative files, the Auditors observed the Pearsall Police were notified in each of the allegations of sexual abuse made at STIPC during the audit period. None of the cases were investigated criminally based on documentation provided and the interview with the Chief of Police. The facility has requested the specific language of subpart (e) be added to the MOU but has not heard back from the Pearsall Police Department.

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

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

Notes:

(a)(b)(c)(d)(e)(f): The Auditor determined compliance with these subparts of the standard after a review of policy 5.1.2-F, Investigating Allegations of Sexual Abuse and Assault and Evidence Collection, which requires "STIPC to have a policy in place to ensure that all allegations of sexual abuse are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations." Policy 2.1.1 also requires "all allegations of sexual abuse/assault be referred for investigation to the Pearsall Police Department and ICE ERO with the legal authority to conduct criminal investigations and each allegation be investigated administratively by the facility." This policy further requires "every allegation of sexual abuse be reported to the Facility Administrator, the Joint Intake Center (JIC), OPR or the DHS OIG, the appropriate ICE FOD/designee, and the Corporate PREA Coordinator." The JIC assesses all sexual abuse allegations, to determine whether the allegation is referred to the DHS OIG or OPR. The DHS OIG has the first right of refusal on all staff, volunteer, or contractor-on-detainee sexual abuse allegations and the OPR reviews and assesses all detainee-on-detainee sexual abuse allegations. Once an allegation referred to the DHS OIG is reviewed and accepted, OPR would not investigate. If an allegation is refused by the DHS OIG, the allegation is referred to OPR to access criminality. Once the allegation is reviewed and accepted by OPR, the investigation is conducted in accordance with OPR policies and procedures and coordinated with law enforcement and facility staff. If an allegation is not criminal in nature, the allegation is referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation. All investigations are closed with a report of investigation. The Agency's policy 11062.2 outlines the evidence and investigative protocols. The Facility Administrator and PSA Compliance Manager confirmed reporting requirements and indicated GEO Corporate Leadership is notified of the investigation by STIPC staff. They also indicated the facility notifies the ERO PREA Field Coordinator who makes all the notifications to the required ICE staff, which the ERO PREA Field Coordinator confirmed during his interview. He also stated he was notified of all 19 allegations reported to the facility during the audit period. During the review of the investigative case files, the Auditors found the notifications to ICE were documented. The STIPC Investigator confirmed all administrative investigations are conducted by trained investigators and documentation of these investigations is maintained for as long as the alleged abuser is detained or employed by GEO, plus an additional five years. The Auditors conducted a review of all administrative investigations completed and closed within the last 12 months and found each was investigated by a trained investigator. The protocols for ICE investigations and GEO investigations are found on their respective web pages (www.ICE.gov/prea) and (www.geogroup.com/PREA).

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "all employees, contractors, and volunteers receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program. The training each staff member receives upon hiring and annually includes: the facility's zero-tolerance policy for sexual abuse and assault; how to fulfill their responsibilities under the agency's sexual abuse and assault prevention, detection, reporting and response policies and procedures; recognition of situations where sexual abuse may occur; the right of detainees and employees to be free from sexual abuse and retaliation for reporting sexual abuse and assault; definitions and examples of prohibited and illegal sexual behavior; recognition of physical, behavioral, and emotional signs of sexual abuse; methods of preventing and responding to such occurrences; how to detect and respond to signs of threatened and actual sexual abuse; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, and intersex (LGBTI) or gender non-conforming detainees; and the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. Each employee, by signature, must acknowledge they have received and understood this training on attachment F (PREA Basic Training Acknowledgement Form) of the policy. The form is used to document pre-service and annual in-service training." The Auditors reviewed 15 random training files (staff, contractors, and volunteers) and found each file contained a signed attachment F form. Furthermore, the random 12 STIPC staff and 2 ICE staff interviewed by Auditors confirmed each had received PREA pre-service and annual refresher training. Those interviewed confirmed the instruction they received included the requirements outlined in subpart (a) of the standard. The interview with the Training Administrator and review of the training curriculum confirmed the subpart (a) requirements are part of the information and is provided during pre-service and annual in-service training as well. The Training Administrator also confirmed that all staff currently assigned to STIPC are current with the agency's PREA training requirement. The Auditor indicated the facility exceeds this standard as the requirement for refresher training is every two years and STIPC requires and provides this training 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): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1, which requires "all contractors and volunteers to receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program on their responsibilities on prevention, detection, and response policies and procedures. The level and type of training provided to volunteers shall be based on the services they provide and the level of contact they have with detainees. All volunteers who have contact with detainees shall be notified of GEO's and the facility's zero-tolerance policies regarding sexual abuse and informed on how to report such incidents. The Training Administrator confirmed all contractors receive the same training STIPC employees receive and attend the same classroom training among STIPC staff annually. The completion and acknowledgment of training

are documented by signature. The Auditor interviewed two contractors, and each confirmed they had received the agency's sexual abuse training that included their responsibilities on prevention, detection, and response policies and procedures. STIPC has approximately ten volunteers who are required by policy 2.1.1, to receive pre-service and annual refresher training on their responsibilities under the agency and facility's sexual abuse policy to include definitions of prohibited acts, communication with LGBTI groups, means of reporting, and ensuring the nearest security staff person is notified if a detainee alleges sexual abuse to them. The Auditor was unable to interview any volunteers as none are allowed on-site during the COVID-19 pandemic, but did review one of their training records that demonstrated a signed document acknowledging the individual received and understood the agency's sexual abuse training.

§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): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1, which requires "the Facility Administrator to ensure the STIPC orientation program, required by the Performance-Based National Detention Standards [PBNDS] 2011, Standard 2.1 Admission and Release and the [facility] detainee handbook, notifies and informs detainees about the facility's zero-tolerance policy for all forms of sexual abuse and assault and includes instruction on prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, employee-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse, including to any employee, including an employee other than immediate point-of-contact line officer (i.e. the PSA Compliance Manager or Mental Health staff), the DHS OIG, and the JIC; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." This policy further requires, "the detainee orientation be provided in formats accessible to all detainees, including those who are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills." Detainees arriving at STIPC are provided an ICE National Detainee Handbook, STIPC Detainee Handbook, DHS-prescribed Sexual Assault Awareness Information pamphlet, and are shown a PREA video available in English or Spanish. The ICE National Detainee Handbook is available in 11 languages and DHS-prescribed Sexual Abuse and Assault Awareness Information pamphlet is available in 9 languages (as noted in 115.16), while the other documents are available in Spanish and English. At the time of the contingency audit, 12 detainees were interviewed, 3 who spoke a language not available in the ICE National Detainee Handbook. Nine of the 12 detainees interviewed spoke a language available in the ICE National Detainee Handbook; however, they indicated to the Auditor that they were not provided with a copy of the Handbook in their language. During the contingency audit phase, the facility was unable to provide documentation that a translated handbook was issued to them. During the on-site visit, STIPC provided evidence to support they now document when a translated handbook is being provided to the detainee, and they are providing detainees, speaking a language not covered through the 11 ICE National Handbook languages, the required subpart (a) requirements in a manuscript through their contracted language line interpreter. The Auditor did review the script information which addressed all the subpart (a) and policy requirements, but was unable to verify the new process as STIPC had not yet received a detainee who did not speak one of the languages currently covered with the ICE National Handbook.

(d): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 which requires "STIPC to post the DHS prescribed sexual assault awareness notice; the name of the PSA Compliance Manager; and the name of local organizations that can assist detainees who have been victims of sexual abuse on all housing unit bulletin boards." A copy of the DHS prescribed sexual assault awareness poster with the PSA telephone number and contact information is also available in the STIPC Detainee Handbook. The Auditor also observed the posting of this poster in each area of STIPC that detainees have access to, including in all housing units. Random detainee interviews also confirmed their knowledge of the poster and the required information. Contact information was also observed for the Rape Crisis Center of San Antonio in each of the detainee living areas.

(e)(f): The Auditor determined compliance with these subparts of the standard based on the review of the intake process and the interview of two intake staff and the Chief of Intake. All three confirmed that upon arrival detainees receive both the DHS-prescribed Sexual Abuse and Assault Awareness Information pamphlet and a copy of the ICE National Detainee Handbook. During the 31 supplemental detainee interviews conducted on-site, most detainees confirmed they had received copies of these documents and signed for receipt of them.

§115.34 - Specialized training: Investigations.

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

Notes:

(a)(b): The Auditor determined compliance with these subparts of the standard based on the review of policy 2.1.1 that requires "facility investigators to be trained in conducting investigations on sexual abuse and effective cross-agency coordination. Investigators shall receive this specialized training in addition to the general training mandated for all employees and documentation of this specialized training shall be maintained." STIPC has 1 primary and 16 backup investigators. The primary investigator confirmed she received specialized training through GEO, and the specialized training was documented in her training record. Auditors confirmed administrative investigations at STIPC over the audit period were conducted by two investigators. Each of the 16 backup investigators' training records were reviewed and contained the required investigative training with certificate. The Auditor's review of the training curriculum confirmed each investigator received training on "how to cooperate with outside investigators." Agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The Auditors reviewed the ICE OPR Investigation Incidents of Sexual Abuse and Assault training curriculum and found the curriculum covered in-depth investigative techniques, evidence collection, and all aspects of conducting an investigation of sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether or not to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The Auditors reviewed the agency provided rosters of trained investigators on SharePoint and determined the documentation was in accordance with the training requirements of this standard.

§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 Auditor determined compliance with these subparts of the standard based on the review of policies 2.1.1 and IHSC Directive: 03-01 Sexual or Physical Assault, Abuse and/or Neglect requires that, "IHSC be responsible for training all full-time and part-time medical and mental health care practitioners who work regularly at STIPC on topic areas including detecting signs of sexual abuse and assault, preserving physical evidence of sexual abuse, responding professionally to victims of sexual abuse and proper reporting of allegations or suspicions of sexual abuse and assault. Medical and

mental health care practitioners shall receive this specialized training in addition to the general training mandated for all STIPC staff." The Auditor interviewed the AHSA who confirmed all full-time and part-time medical and mental health practitioners at STIPC receive the required PREA training plus the specialized training to include the additional topics required under subpart (b). The Auditor was provided training signature sheets from the 2019 and 2020 medical and mental health training that staff completed. The AHSA stated the required additional specialized training is provided through the Performance and Learning Management System (PALMS) and provided the Auditor with the topics covered in the training, that meets the subpart requirement.

(c): The Auditor determined compliance with this subpart of the standard after reviewing policy 2.1.1 that requires, "facility medical staff to not participate in sexual assault forensic medical examinations or evidence gathering. Forensic examinations shall be performed by a SANE or SAFE." The interview with the AHSA confirmed this policy restriction and informed the Auditor, staff would only stabilize the" victim and prepare him/her for transport if required. This policy was approved by the OIC.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires, "all detainees be assessed during 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. Each new arrival at STIPC shall be kept separate from the general population until he/she is classified and may be housed accordingly. Interviews with intake staff confirmed each detainee arriving at STIPC is assessed for vulnerability utilizing the GEO PREA Risk Assessment Tool (attachment C of policy)." This document utilizes the following criteria to assess detainees for risk and sexual victimization and abusiveness: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as LGBTI or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainees' own concerns about his or her physical safety. These intake officers also stated that by policy they also consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to them and the facility, in assessing their risk of being sexually abusive. In addition to this screening instrument, persons tasked with screening conduct a thorough review of any available records (e.g., medical files or, Record of Deportable/Inadmissible Alien (Form I-213) and the Record of Persons and Property Transfer (Form I-216) that can assist them with the risk assessment. Policy 2.1.1 further requires, "the detainee assessment be completed on intake and their initial classification be completed within 12-hours of the detainee's arrival. Detainees, by policy, are kept separate from general population until the assessment and classification processes are completed." The policy requires the PSA Compliance Manager to maintain an "at risk log" of potential victims and potential abusers determined from the GEO PREA Risk Assessment Tool. The "at risk log" will be kept current and include housing locations. Following any reported allegation of sexual abuse, the PSA Compliance Manager will ensure victims are placed on the "at risk" log as soon as possible and tracked as a potential victim and housed separate from potential abusers pending the outcome of the investigation. If the investigation is determined "unfounded," the victim may be removed from the "at risk" log. The PSA Compliance Manager will also maintain a tracking log of those individuals who self-identity as LGBTI with their housing location as a result of information obtained during the risk screening. The Auditor reviewed 14 detainee detention files and found completed risk assessments were conducted utilizing the GEO PREA Risk Assessment Tool and on the day of the detainees' arrival. The interview with the random detainees confirmed their classification and risk assessment was completed within their first couple hours of arrival and the detention file reviews also documented each detainee received his/her initial classification and vulnerability assessment within 12-hours of arrival. The Chief of Classification confirmed that detainees remain in the intake area until the classification process is completed. All of the random detainees interviewed confirmed that they remained in the intake area until they were classified.

(e): Policy 2.1.1 requires "STIPC to reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment and at any other time when warranted based upon the receipt of additional, relevant information. These reassessments will include a face-to-face interview with the detainee. All reassessments are to be documented on the PREA Vulnerability Reassessment form (attachment D of the policy) and placed in the detainee's detention file. The Performance-Based National Detention Standards (PBNDS) 2011 requires, "All facility classification systems shall ensure that a detainee is reassessed and/or reclassified. Reclassification assessments shall take into account, among other factors, the detainee's risk of victimization or abusiveness. Staff shall record whether a classification process is being conducted for an initial classification or subsequent reclassification: The first reclassification assessment shall be completed 60 to 90 days after the date of the initial classification; Subsequent reclassification assessments shall be completed at 90-to 120-day intervals. And Special Reclassification Assessments requires, 'Staff shall complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (SMU), following an incident of abuse or victimization, and at any other time when warranted based upon the receipt of additional, relevant information, such as after a criminal act, or if a detainee wins a criminal appeal, is pardoned or new criminal information comes to light. If it is documented, suspected or reported that a detainee has been physically or sexually abused or assaulted, the victim's perception of his or her own safety and well-being shall be among the factors considered." The Auditor's review of detention files found that detainees held at STIPC beyond 60 days received a reclassification and vulnerability reassessment every 60 days. The Auditor reviewed a detention file of a detainee who alleged sexual abuse which inidicated this individual was provided the special assessment as required but six days after the allegation was made and not within 24 hours as required per the PBNDS.

DOES NOT MEET: (e): The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The Auditor requires facility staff responsible for completing assessments for risk of victimization and abusiveness to receive refresher training on when an assessment is required per the PBNDS. The Auditor further requests to receive signed acknowledgments of staff completing the training and, if available, any reassessments completed based upon receiving additional, relevant information or following an incident of abuse or victimization conducted within the required time frame.

(f): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that "prohibits detainees from being disciplined for refusing to answer, or for not disclosing complete information in response to questions asked in subpart (c); whether the detainee has a mental, physical or developmental disability, identifies as LGBTI or gender non-conforming, experienced prior sexual victimization or has any concerns about his or her physical safety." The Chief of Intake and the two intake officers confirmed detainees are not disciplined for refusing to answer any of the questions on the GEO PREA Risk Assessment Tool or the PREA Vulnerability Reassessment Form.

(g): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires STIPC to "implement appropriate controls on the dissemination of responses to questions asked related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees." The policy further requires "sensitive information be limited to staff on a need-to-know basis only for the purpose of treatment, programming, housing and security and management decisions." The classification officer confirmed appropriate controls are placed on all detainee records, and information including risk assessments are maintained in the detainee detention files and secured in the records room file cabinet, which is under double lock and restricted key. The Auditor observed intake documents under strict control during the on-site visit.

§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): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires "STIPC to use the information from the risk assessment to determine housing, bed, work, education and programming assignments in order to keep potential victims away from potential abusers." The Chief of Intake indicated these housing, bed, work, education, and programming assignments are made on an individual basis after reviewing the detainee's GEO PREA Risk Assessment Tool, his/her medical assessment, and Form I-213 document, when available. He stated that all classification determinations outlined in subpart (a) are made on an individualized basis, taking into account these available documents to ensure the safety of each detainee. Each detainee is individually interviewed and assessed prior to any assignment. The Auditor observed this individualized assessment in each of the 13 detention files that were reviewed

(b)(c): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires STIPC, "when making assessments and housing decisions for transgender and intersex detainees, to consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. A medical or mental health practitioner shall be consulted as soon as practicable on these assessments and placement decisions which shall not be based solely on identity documents or physical anatomy of the detainee." The policy further states "transgender and intersex detainees may be housed in medical for up to 72 hours (excluding weekends, holidays and emergencies) until the appropriate housing determination is made by the facility's Transgender Care Committee (TCC)." The TCC is comprised of the Facility Administrator or Assistant Facility Administrator, Chief of Security, Chief of Intake, medical and/or mental health staff, and PSA Compliance Manager. The PSA Compliance Manager and Chief of Intake confirmed that STIPC has had over 25 instances within the audit period, of transgender detainees being placed at the facility and no intersex detainees. The Auditor reviewed a sampling of TCC Summaries (attachment E of policy) documenting review by the TCC prior to the placement of a transgender or intersex detainee in any housing unit and completed within the 72-hours requirement. The PSA Compliance Manager further stated that transgender detainees are assessed every six months by policy and allowed the opportunity to shower separately from other detainees if requested. The one transgender file available on-site was reviewed by the Auditor; the file indicated the detainee was not housed at the facility long enough to require a reassessment. There were no transgender detainee at the facility during the on-site visit.

§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)(e)(f): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that outlines the procedures to be followed governing the management of the RHU. STIPC must "document detailed reasons for placement of an individual in administrative restriction on the basis of a vulnerability to sexual abuse or assault." The policy requires, "the use of administrative restriction to protect detainees vulnerable to sexual abuse or assault be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing option exists. STIPC may assign detainees vulnerable to sexual abuse or assault to administrative restriction for their protection until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days." The interview with the Segregation Supervisor confirmed detainees are not placed in administrative restriction unless there is absolutely no other housing alternative, and that the placement is not to exceed 30 days. The Segregation Supervisor and Facility Administrator confirmed that if administrative restriction is used to protect vulnerable detainees, the detainee would have access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable. They also stated that restricted housing has not been utilized to protect detainees vulnerable to sexual abuse or assault during the audit period. The Facility Administrator informed the Auditor that, by policy, any detainee victim placements in restricted housing must be documented and reported to the FOD within 72 hours of their placement to determine if ICE can provide additional assistance. This policy was developed in consultation with the ICE ERO OIC. The interview with the SDDO confirmed that he makes all ICE notifications to the FOD within 72 hours once STIPC notifies him.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 2.7.3 RHU-Administrative and Disciplinary Restriction that requires "STIPC follow administrative restriction reviews that requires a supervisory staff member to conduct a review, within 24 hours of a detainee's placement in administrative restriction, to determine whether the restriction is still warranted and complete a supervisory review of any detainee victim or vulnerable detainee placed in administrative segregation, within 72 hours of their placement in segregation, to determine if the placement is still warranted." This policy also requires "a supervisory staff member conduct, at a minimum, an identical review after the detainee has spent seven days in administrative segregation and every week thereafter for the first 30 days, and then every 10 days thereafter". The Segregation Supervisor during his interview confirmed STIPC has not needed to conduct any reviews in the audit period, but if one were to be completed, it must be documented in accordance with the aforementioned timeframes by the supervisor on DHS Sexual Assault/Abuse Available Alternatives Assessment (attachment G of the policy).

§115.51 - Detainee reporting.

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

Notes:

(a)(b): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires STIPC provide multiple ways for detainees to privately report sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The policy also requires STIPC provide contact information to detainees for relevant consular officials, the DHS OIG or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents. As noted earlier in the report, detainees are required to receive an orientation upon arrival that includes, at a minimum, instruction on the six requirements outlined in subpart (a) of standard 115.33. The third requirement is an "explanation of methods of reporting sexual abuse…" The PSA Compliance Manager confirmed detainees may report allegations to a public or private agency not associated with the facility, GEO, or agency, which includes the JIC or/and DHS OIG. Interviews with three detainees, who speak a language other than one of the 11 translated in the ICE National Detainee Handbook, were unaware of

how to report sexual abuse. The detainees informed the Auditors that they had not received reporting information and that the DHS-prescribed Sexual Assault Awareness posters located in each housing unit are not understandable to them. However, a review of these detainees' files noted each had signed receiving this reporting information. The facility has the consulate numbers and the OIG line to meet the requirement of at least one means for detainee to report to a public or private agency not associated with the facility. It should be noted, the Auditor checked the Detainee Reporting Information Line (DRIL) from three different housing locations and was unable to make any contact to report an allegation. The detainee also would have to utilize a PIN to contact DRIL, which would identify the detainee and not allow the detainee to remain anonymous. Nonetheless, the other available methods meet the standards requirement. Allegations were made in the following manner: ten allegations were made to staff; two allegations were reported occurring at other facilities; one allegation was made through the grievance office; one allegation was reported, occurring at STIPC, from another facility; one allegation was made to the PSA Compliance Manager through the detainee phone; one allegation was submitted electronically through the detainee tablet, and one was reported through the DRIL.

Recommendation: The Auditor tried to contact the DRIL from three different housing locations and was unable to make any connection; therefore, no detainees would be able to report an allegation, or do so anonymously, as the facility requires detainees to utilize their PIN when dialing the DRIL. The facility needs to repair the phone line, ensuring it is operational, and that the detainee can anonymously make a call to DRIL

(c): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 which requires all employees at STIPC to accept reports of sexual assault made to them verbally, in writing, anonymously and from third parties, and promptly document any verbal reports. The Auditors interviewed random staff who confirmed the STIPC policy requirement that they are to accept and immediately report allegations of sexual abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors. Ten allegations were reported to the staff and documented as verified during the Auditor's review.

§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): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 and the STIPC Detainee Handbook (in Spanish and English) which require, "STIPC permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint and shall not impose a time limit on when a detainee may submit a grievance regarding allegation of sexual abuse." The policy further requires, "STIPC to implement written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse." The Auditor interviewed the Grievance Officer who confirmed she immediately notifies the PSA Compliance Manager and Facility Administrator of all allegations of sexual abuse made through the grievance office. She also stated that allegations of sexual abuse are treated as an "emergency" grievance and that all medical emergencies are brought immediately to the proper medical personnel for assessment. Decisions on this type of grievance are responded to within 5 days of receipt and responses to an appeal of the grievance decision are responded to within 30 days. Policy 2.1.1 requirements and the interview with the Grievance Officer confirmed STIPC notifies, as required, the ERO PREA Field Coordinator of the allegation. During his interview, the SDDO confirmed he is notified when any sexual abuse allegation is submitted through the grievance office. During the audit period, the STIPC grievance office received an anonymous unsigned report of an allegation of sexual abuse. The Grievance Officer reviewed the information, and it was assigned a grievance number and forwarded to the PSA Compliance Manager who notified the ERO PREA Field Coordinator of the allegation. It was also forwarded to the PREA investigator to investigate it to the extent possible. There was no response to the detainee since there was no name to follow-up with.

(f) The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 which states, "detainees may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives." Interviews conducted with 12 random security staff confirmed their knowledge of the grievance process on reporting allegations of sexual abuse by detainees and their responsibility to take reasonable steps to expedite requests for assistance from these other parties if needed. Most detainees interviewed confirmed they were aware of the grievance process and it could be used to address sexual abuse/assault.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires, "STIPC make available to detainees information about local organizations that can assist those who have been victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If local providers are not available, STIPC shall make available the same information about national organizations". The policy further requires "STIPC to maintain or attempt to enter into agreements with community service providers to provide detainees with confidential emotional support services related to the sexual abuse while in custody. If local providers are not available, national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime should be utilized. STIPC shall maintain copies of all agreements or documentation showing unsuccessful attempts to enter into such agreements." As noted in standard 115.21, STIPC has an MOU with a local hospital (MSTH) to provide detainee victims of sexual abuse access to outside victim advocates for emotional support services during the forensic exam and interviews with police. This information is available in the STIPC Detainee Handbook. The PSA Compliance Manager confirmed phone communication and detainee mail with the Rape Crisis Center is not monitored. Detainees are informed prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. This information is outlined in Policy 2.1.1 and noted in the STIPC Detainee Handbook. The facility's Investigator and PSA Compliance Manager confirmed they provide each detainee alleging sexual abuse the contact information for the Rape Crisis Center within the first hour after being made aware of the allegation. The eight investigative files reviewed noted the detainees were provided this advocacy information. The one detainee interviewed, who alleged sexual abuse, informed the Auditor he was provided the Rape Crisis Center information by the PSA Compliance Manager. As noted in 115.21 the facility had no MOU with the Rape Crisis Center-San Antonio. The Auditor interviewed a supervisor from the Rape Crisis Center; the Supervisor indicated the facility has spoken with them about formalizing an MOU outlining specific responsibilities, but it had yet to be addressed by STIPC. However, the facility did list the contact information for them in their STIPC Detainee Handbook on page 22. During the provisional audit report period, the Auditor recommended the facility formalize an agreement with the Rape Crisis Center. As of the issuance of this report, the facility and Rape Crisis Center have entered into an MOU. She also indicated they are not a reporting facility but did receive and forward a reported allegation to STIPC.

§115.54 - Third-party reporting.

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

Notes:

The GEO's public website outlines the facility's methods of receiving third-party reports of sexual abuse or assault on behalf of detainees. Policy 2.1.1 requires, "STIPC display third-party reporting posters in all public areas in English and Spanish to include lobby, visitation and staff break areas within the facility. The GEO web page (www.geogroup.com/PREA) and ICE website (https://www.ice.gov) include third-party reporting information on behalf of any detainees as well. The facility received third-party allegations during the previous 12 months: one from the Rape Crisis Center and one from the DRIL. The Auditor did observe third-party reporting information in the detainee visiting process areas during the on-site visit. Random detainee interviews confirmed their knowledge of third-party reporting, if needed.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "all STIPC staff to immediately report, in accordance with GEO policy, any knowledge, suspicion, or information regarding an incident of sexual abuse or assault that occurred in a facility whether or not it is a GEO facility; retaliation against detainees or employees who reported such an incident or participated in an investigation about such incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Employees and contractors are required to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in any facility, whether or not it is a GEO facility; retaliation against detainees or employees who reported such an incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation." The policy also "prohibits employees from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility; or to make medical treatment, investigation, law enforcement, or other security and management decisions." As previously noted, this policy was reviewed and approved by the OIC. The 12 random staff interviewed confirmed their knowledge on reporting requirements outlined by the policy and required by the standard. Each of them indicated reporting requirements are readily available in the policy and provided to them in both the pre-service training and annual refresher training. The Auditor reviewed the training curriculum for pre-service and the annual refresher and found the reporting information and requirements detailed as required by the standard. The PSA Compliance Manager informed the Auditor, and it was also confirmed during staff interviews, that staff may report sexual abuse outside their chain of command to the Chief of Security, upper- level executives privately, the employee hotline, or contact the Corporate PREA Coordinator directly to privately report these types of incidents.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires, "allegations of sexual abuse in which the alleged victim is under the age of 18 or considered a vulnerable adult under State or local vulnerable persons statute, be reported to designated State or local services agencies under applicable mandatory reporting laws." The Facility Administrator and PSA Compliance Manager confirmed that if any vulnerable adult was ever the victim of a sexual assault the facility would notify the Pearsall Police Department as it does with every allegation. The facility has not had any incidents involving a vulnerable adult. The PAQ and interviews with the Facility Administrator and PSA Compliance Manager also confirmed there are no juveniles or vulnerable adults housed at STIPC.

§115.62 - Protection duties.

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

Notes:

The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires "when an employee or facility staff member has reasonable belief that a detainee is subject to substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." The Auditors interviewed 12 security staff, 2contractors, and the Facility Administrator about this type of situation and each of them answered indicating the detainee's safety would be their primary concern. The action each would take varied on the situation, location of the incident and their employment position. Removing the detainee from danger would be their initial focus. The Facility Administrator, PSA Compliance Manager, and the PAQ confirmed STIPC had no detainees at substantial risk of imminent sexual abuse within the audit period.

§115.63 - Report to other confinement facilities.

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

Notes:

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "in the event that a detainee alleges that sexual abuse occurred while confined at another facility, STIPC shall document those allegations and the Facility Administrator or Assistant Facility Administrator shall contact the Facility Administrator or designee where the abuse is alleged to have occurred and notify the ICE Field Office as soon as possible, but no later than 72 hours after receiving the notification. The facility shall maintain documentation that it has provided such notification and all actions taken regarding the incident. Copies of this documentation shall be forwarded to the PSA Compliance Manager and Corporate PREA Coordinator. Any notifications of alleged abuse received by STIPC will ensure that the allegation is investigated in accordance with PREA standards and reported to the appropriate FOD." The Facility Administrator and PSA Compliance Manager indicated the facility received two allegations of sexual abuse from detainees arriving at STIPC having occurred in other facilities. The Auditor was provided the notifications sent to each of the facility administrators indicating each was notified within 72 hours of being informed of the allegation. The Facility Administrator and PSA Compliance Manager also confirmed STIPC received information on an allegation of sexual abuse that occurred at STIPC reported by another facility. That allegation was reported and investigated as required by policy 2.1.1 and verified by the Auditor during the on-site visit.

§115.64 - Responder duties.

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

Notes:

(a): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires, "upon learning of an allegation that a detainee was sexually abused, or if the employee sees abuse, the first security staff member to respond to the incident shall separate the alleged victim and abuser; immediately notify the on-duty security supervisor and remain on the scene until relieved by responding personnel; preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; and if the sexual abuse occurred within 96 hours, the alleged victim and abuser shall be separated to ensure that the alleged victim and abuser do not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating until

the forensic examination can be performed." The policy further requires, "a security staff member of the same sex shall be placed outside the area where the detainee is secured for direct observation to ensure these actions are not performed." During the review of the eight investigative files, the Auditors confirmed the responding security staff member followed the protocols as required by the situation and outlined in the policy. The interviews with the 12 security staff confirmed their responsibilities as responders to incidents of sexual abuse. All responses covered the subparts and policy protocols.

(b): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires, "if the first 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, remain with the alleged victim, and notify security staff. During interviews with two non-security staff, each confirmed they would ensure the victim and perpetrator were separated, not allow either to destroy evidence, and immediately call for a security staff member. The Auditor reviewed the reporting method of the 15 closed PREA investigation files, the Auditor confirmed that 8 of the 15 allegations cases were reported to non-security staff and that staff immediately contacted a security staff person.

§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): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "STIPC follow their written plan to coordinate the actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to incidents of sexual abuse. The plan titled "SAAPI Coordinated Response" is maintained in the Facility Emergency Plan Binder." The Auditors reviewed this plan that coordinates the actions and responsibilities for first responders, medical and mental health practitioners, investigators, and facility leadership. The Facility Administrator and PSA Compliance Manager confirmed STIPC utilizes the plan in every response to an allegation of sexual abuse. The Auditor did an inspection and in-depth review of eight closed investigative files. The Auditor found the investigative files content documented the multidisciplinary and coordinated responses taken by staff members at STIPC in line with the facility emergency plan.

(c)(d): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that "requires whenever a victim of sexual abuse is transferred between DHS immigration detention facilities, 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." The policy further requires, "if the detainee victim of sexual abuse is transferred to a non-DHS facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical and/or social services, unless the victim requests otherwise." The Facility Administrator, AHSA, PSA Compliance Manager, and the PAQ confirmed that STIPC had no detainee make an allegation of sexual abuse prior to being transferred to another facility by ICE. The Facility Administrator and PSA Compliance Manager confirmed that if a detainee were to be transferred under these conditions a Notification of Transfer would be completed in accordance with the aforementioned procedures and forwarded to the ICE ERO Assistant Field Office Director (AFOD). The AHSA indicated that typically someone from medical services would make telephone contact with the receiving facility to provide this information as well.

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

The Auditor determined compliance with the standard based on review of policy 2.1.1 that requires "when an employee, contractor, and volunteer is suspected of perpetrating sexual abuse, he/she shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Separation orders requiring "no contact" will be documented by facility management via email or memorandum within 24 hours of the reported allegation. The email or memorandum shall be printed and maintained as part of the related investigation file." The PSA Compliance Manager and Facility Administrator both confirmed any employee, contractor, or volunteer who was an alleged perpetrator of sexual abuse of a detainee would be removed from any further contact with detainees, pending the investigation outcome. STIPC had four allegations of sexual abuse made against staff during the audit period. The Auditors found separation orders in each of the investigative files, removing and prohibiting the staff member from any contact with detainees until the completion of the investigation.

§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): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that "prohibits employees, contractors, and volunteers, and 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." This policy further requires, "STIPC to employ multiple protection measures, such as housing changes, removal of alleged staff abusers from contact with victims, and emotional support services for detainees and employees who fear retaliation for reporting sexual abuse or for cooperating with investigations. The PSA Compliance Manager is the designated staff person responsible for monitoring staff and detainee retaliation." During the interview with the PSA Compliance Manager she confirmed retaliation monitoring begins the day the allegation is made and continues for a period of at least 90 days, if not unfounded, and could continue as long as monitoring for retaliation is required. She documents this monitoring on the "Protection from Retaliation Log" (attachment B of policy 2.1.1). She indicated detainee monitoring would include a review of the detainee disciplinary reports and/or housing or program changes. She further stated monitoring would include reviewing negative performance reviews, time off refusals, and change of duties or reassignment. The Auditor reviewed eight closed investigative files demonstrating retaliation monitoring for at least 90 days except in the cases where the detainee was released from STIPC. The PSA Compliance Manager confirmed STIPC had no cases of employee retaliation monitoring or any allegations of retaliation by a detainee or staff member within 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)(b)(c)(d): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires. "the facility take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible subject to the requirements of standard 115.43." The Facility Administrator informed the Auditors that the use of administrative restriction for detainee victims of sexual abuse would be highly unlikely and only used as a last resort. He indicated his preferred option would be the use of a hospital bed in medical instead for any victim. He also confirmed that the use of the RHU has not occurred at STIPC during the audit period but if it were to be used, he would

notify the OIC within 72 hours and the detainee would not be held longer than 5 days, except in unusual circumstances or at the request of the detainee. He stated that if a detainee victim was placed in administrative restriction, they would not be returned to the general population until the completion of a vulnerability reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b)(c)(e)(f): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 and policy 5.1.2 F that require "when STIPC conducts its own administrative investigations into allegations of sexual abuse, it shall do so promptly, thoroughly, and objectively for all allegations of sexual abuse and by trained investigators." The facility investigator confirmed she conducts an administrative investigation for every allegation of sexual abuse regardless if a criminal investigation is conducted, and after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. She indicated her investigation, if no criminal investigation by the Pearsall Police department or ICE is conducted, she would begin the investigation within 24 hours of the allegation being made. She also confirmed she is the point of contact for any outside investigative agency and cooperates with them by providing assistance when needed and remains informed about the progress of the investigation. She detailed for the Auditor her investigative protocols for the administrative investigations indicating they are based on direct and circumstantial evidence; available physical DNA evidence; available electronic monitoring data; interview notes from the alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse or assault, involving the suspected perpetrator. She indicated when conducting her administrative investigations, she assesses the credibility of the alleged victim, suspect, or witness, based on evidence, not on the individual's status as a detainee, employee, or contractor. She also stated she does not require any detainee, who alleged sexual abuse or assault, to submit to a polygraph as a condition of the investigation. She also confirmed the departure of the alleged abuser or victim from employment or control of the facility does not affect the investigation continuing until completion. As noted earlier, both of these policies, outlining investigative protocols, were reviewed, and approved by the OIC. The review of eight investigation files confirmed all the element requirements of the policy and standard subpart requirements were followed and the investigations appeared to be prompt, thorough, and objective and completed by a trained investigator.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with the standard based on the review of policy 2.1.1 and policy 5.1.2.F that require "facilities shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated." The facility's Investigator confirmed the evidence standard she uses when determining a sexual abuse investigation is the preponderance of evidence. During the review of the eight investigative files, it appeared to the Auditor that a preponderance of the evidence was the standard used in determining the outcome of the investigations.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with the standard based on the review of policy 5.1.2 F that requires "at the conclusion of an investigation, the facility investigator or staff member designated by the Facility Administrator inform the individual who made the allegation of sexual abuse in writing, whether the allegation has been substantiated, unsubstantiated, or unfounded through the "Notification of Outcome of Allegation" form." The Investigator confirmed at the conclusion of each investigation the detainee is personally notified of the investigation outcome and must sign that the notice was provided to them. The Auditor found these forms in each of the eight reviewed investigative files. The Investigator indicated if the detainee was no longer at the facility but at another ICE facility the notification would be forwared to that facility otherwise it just remains in the investigative file.

§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): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "staff to be subject to disciplinary or adverse action, up to and including removal from their position and federal service, for substantiated allegations of sexual abuse or for violating agency and/or facility sexual abuse policies." The policy regarding the disciplinary and adverse actions for violating rules prohibiting sexual abuse was reviewed and approved by the OIC. The Facility Administrator, Human Resources, and the PSA Compliance Manager confirmed that removal from their position and from federal service is the presumptive disciplinary sanction for any staff member who engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer. There were four allegations of sexual abuse involving staff during the audit period. Two of the allegations were open, one was determined unsubstantiated, and one was determined unfounded.

(c)(d): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "any removals or resignations in lieu of removal, for violating the agency and/or facility sexual abuse policies, be reported to appropriate law enforcement agencies, and unless the activity was clearly not criminal, and licensing bodies to the extent known." The Facility Administrator confirmed that he is responsible for making these notifications if and when it becomes necessary. He also confirmed all allegations of sexual abuse are immediately reported to the Pearsall Police Department, regardless of if the staff member resigns or not. The Auditor found notifications made to the Pearsall Police Department in each of the eight investigative files reviewed. There were no reported terminations of an STIPC employee for violation of the facility's zero-tolerance policy.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees. The facility shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. Such incidents shall also be reported to law enforcement agencies unless the activity was clearly not criminal." The policy further states "contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact, pending the outcome of an investigation. The facility shall take

appropriate remedial measures; and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse; but have violated other provisions within these standards." The Facility Administrator stated any contractor or volunteer found to have violated any part of their zero-tolerance policy (2.1.1) would face immediate removal from the facility and would be prohibited from future contact with any detainee. He also confirmed there were no reported incidents requiring the removal of a contractor or volunteer within the audit period and, if there were, they would be reported to the OIC, Pearsall Police Department and any licensing body.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires, "the facility shall subject a detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engages in sexual abuse. At all steps in the disciplinary process any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future." This policy further requires "the facility have a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures that considers whether a 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 facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, 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 interviews with the Facility Administrator and the PSA Compliance Manager discussed the STIPC disciplinary process to the Auditor. Each stated that prior to disciplinary hearings the mental competency of the abuser is evaluated and if required would be taken into consideration during the hearing. The Facility Administrator confirmed that incidents involving staff, that consented, would not result in discipline to the detainee. He also informed the Auditor that the facility disciplinary process allows for progressive levels of reviews, appeals, procedures, and documentation procedures. The Facility Administrator and the PSA Compliance Manager also confirmed no detainee was disciplined for violating the facility's sexual abuse policy during the audit period.

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

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

Notes:

(a)(b)(c): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires, "if, during the intake assessment, persons tasked with screening determine that a detainee is at risk for either sexual victimization or abusiveness, or if the detainee has experienced prior victimization or perpetrated sexual abuse, the detainee shall be immediately referred to a qualified medical and/or mental health practitioner for medical and/or mental health follow-up as appropriate." The policy further states "when a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of the assessment and when a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." The Chief of Intake, a classification officer, and the AHSA confirmed the referral for medical or mental health follow-up is initiated through email and the detainee is typically seen the same day but always within the standard and policy time requirements. Medical and mental Health practitioners confirmed when a medical follow-up is initiated, the detainee receives a health evaluation typically the same or next day no later than two working days from the date of the assessment. The Auditor interviewed one detainee who reported prior victimization who stated he was offered medical/mental health services and was seen by both medical staff and mental health staff on his day of arrival. This medical contact was further verified through review of the detainee medical record. The AHSA confirmed STIPC offers mental health services to known detainee abusers recognized during the intake process. He also stated that the facility had no known abusers identified through the risk assessment upon arrival, but if the facility had, a referral would be made and services offered.

§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): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires, "victims of sexual abuse in custody receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by medical and mental health practitioners. This access includes offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with an investigation arising out of the incident." The Auditors were provided ten randomly chosen detainee medical records and investigative files. The review of these files confirmed each of the ten alleged victims were immediately brought to the medical unit and evaluated by medical staff. The AHSA confirmed this process was conducted for all ten cases and this is the standard procedure for evaluations conducted for all allegations of victimization. He also indicated victims would have access to a medical examination (forensic), with their consent and at no cost to the detainee and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor interviewed one detainee, during the on-site visit, who alleged sexual abuse. He informed the Auditor he was speaking to a mental health practitioner when he informed her of the abuse. He was immediately seen by medical staff. He also informed the Auditor that he had follow-up meetings with both medical and mental health and was never charged for services. He also stated he was never compelled to cooperate with the investigation.

§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)(f): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires, "STIPC offers medical and mental health evaluations and treatment, where appropriate, to all victims of sexual abuse while in immigration custody. The evaluation and treatment should include 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. These services shall be provided in a manner that is consistent with the level of care the individual would receive in the community and without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with an investigation arising out of the incident." The HSA confirmed the facility offers all detainees, who experience sexual abuse while in detention, medical and mental health services consistent with the community level of care and continued treatment without cost to the detainee regardless of if he/she names the abuser or cooperates with any investigation arising out of the incident. The Auditor interviewed one detainee, during the on-site visit, who alleged sexual abuse. He informed the Auditor he was speaking to a mental health practitioner when he informed her of the abuse. He was

immediately seen by medical staff. He also informed the Auditor that he had follow up meetings with both medical and mental health and was never charged for services. He also stated he was never compelled to cooperate with the investigation. The Auditor also reviewed investigative files demonstrating STIPC documented the detainees who alleged sexual abuse were seen by medical and mental health.

(d)(e): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires "victims of sexually abusive vaginal penetration by a male abuser, while incarcerated, shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services." The policy further requires victims shall also be referred tests for sexually transmitted infections as medically appropriate. The AHSA confirmed that his medical and mental health departments provide on-site crisis intervention services to include emergency contraception, pregnancy testing, sexually transmitted infections and other infectious diseases testing, and prophylactic treatment to victims, if necessary. There were no allegations made at STIPC within the audit period requiring any of the services outlined in the standard or policy.

(g): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires "STIPC to attempt to conduct a mental health evaluation on all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by mental health practitioners." The policy states: "known abusers" are those detainee abusers in which a SAAPI investigation is determined to be either administratively or criminally substantiated. In the 13 detainee-on-detainee allegations, none were substantiated requiring STIPC to conduct a mental health evaluation on the abuser. The AHSA confirmed STIPC offers mental health services to known detainee abusers recognized during the intake process and to those detainees found to have violated the agency zero- tolerance policy.

§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): Policy 2.1.1 requires "a sexual abuse incident review be conducted within 30 days of the conclusion of every sexual abuse investigation by the facility incident review team, utilizing DHS Sexual Abuse or Assault Incident Review form (attachment J of the policy)." The PSA Compliance Manager confirmed the facility review team consists of upper-level management officials, the local PSA Compliance Manager, medical and mental health practitioners, and the Agency PREA Coordinator. The PSA Compliance Manager also confirmed any recommendations for improvement if outlined in this review must be adopted or document the reasons for not doing so. She also stated the completed review is provided to both the Corporate PREA Coordinator and the agency's PSA Coordinator. The Auditor was informed by both the facility's Investigator and the PSA Compliance Manager that although STIPC may have concluded their administrative investigation, it does not get forwarded to Corporate for approval until ICE has concluded their investigation. ICE staff, usually the SDDO, is the chairperson for the incident review team. The documentation does show that the incident reviews are conducted within 30 days after ICE has completed their investigation, but it can be months after STIPC has finished theirs.

Recommendation: Although the time frames of the standard are met, the Auditor recommends that STIPC forward their investigation to Corporate upon completion and then conduct an Incident Review on the administrative investigation for a timely review of the incident and address any recommendation/corrective action that may be identified during the review. The facility should also conduct a supplemental review if the ICE investigator identifies any issues not previously identified by the facility upon completion of an ICE OPR investigation.

(b): The Auditor determined compliance after the review of the DHS Sexual Abuse or Assault Incident Review form that requires the facility's review team to look at race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification; status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, while conducting their incident review. The reviews completed by the facility's review team were noted in attachment J and included each of the subpart elements of this standard and were included in the eight investigative files the Auditors reviewed.

(c): The Auditor determined compliance with this subpart of the standard based on review of policy 2.1.1 that requires "an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be documented utilizing the "DHS Annual Review of Sexual Abuse Incidents" (attachment K of the policy) and provided to the Facility Administrator, FOD or his/her designee and Corporate PREA Coordinator upon completion." The PSA Compliance Manager provided the Auditors with the annual review completed in November 2019 and 2020 and indicated they were distributed to the Facility Administrator, FOD, and Corporate PREA Coordinator.

§115.87 - Data collection.

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

Notes:

(a): The Auditor determined compliance with these subparts of the standard based on review of policy 2.1.1 that requires, "STIPC maintain in a secure area, 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, if necessary, and/or counseling in accordance with the PREA standards and applicable agency policies and established schedules." The PSA Compliance Manager confirmed data collected with respect to any investigation of sexual abuse is securely maintained in her office under double lock and key, with access restricted to only staff with a need to know. She indicated the records are retained for at least five years, after the date of the initial collection, unless federal, state, or local law requires otherwise

§115.201 - Scope of audits.

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

Notes:

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

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	36
Number of standards not met:	1
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 7/22/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 7/22/2021

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 7/22/2021

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-(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:	San Antonio Field Office		
Field Office Director:	Daniel Bible		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1777 NE Loop 4410 Floor 15, San Antonio, TX, 78217		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	South Texas ICE Processing Center (STIPC)		
Physical address:	566 Veterans Drive, Pearsall, TX 78061		
Mailing address: *(if different from above)*			
Telephone number:	830-334-2939		
Facility type:	CDF		
Facility Leadership			
Name of Officer in Charge:	(b) (6)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	8380-334-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	830-334-(b) (6), (b) (7)(C)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) audit of the South Texas ICE Processing Center (STIPC) was conducted on May 4-5, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt, a contractor with 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, (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR), and External Reviews and Analysis Unit (ERAU) during the audit report review process. The STIPC is privately owned by the GEO Group and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and houses male and female adult detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held detained at STIPC are from Mexico, Honduras, and Cuba. STIPC is located in Pearsall, Texas.

During the audit, the Auditor found the STIPC met 36 standards, had two standards (115.17, 115.31) that exceeded, had two standards (115.14, 115.18) that were non-applicable, and one non-compliant standard (115.41). As a result, the facility was placed under a Corrective Action Period to address the non-compliant standards. On December 13, 2021, the Auditor was provided the ICE PREA Corrective Action Plan (CAP) from the External Reviews and Analysis Unit (ERAU) that was reviewed and approved by the auditor to determine compliance with the one standard that did not meet compliance during the PREA audit site visit and documentation review. The final supplied documentation was reviewed by the Auditor on December 13, 2021, and it was determined standard 115.41 is 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. 41 - Assessment or risk of victimization and abusiveness

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(e): Policy 2.1.1 requires "STIPC to reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment and at any other time when warranted based upon the receipt of additional, relevant information. These reassessments will include a face-to-face interview with the detainee. All reassessments are to be documented on the PREA Vulnerability Reassessment form (attachment D of the policy) and placed in the detainee's detention file. The Performance-Based National Detention Standards (PBNDS) 2011 requires, "All facility classification systems shall ensure that a detainee is reassessed and/or reclassified. Reclassification assessments shall take into account, among other factors, the detainee's risk of victimization or abusiveness. Staff shall record whether a classification process is being conducted for an initial classification or subsequent reclassification: The first reclassification assessment shall be completed 60 to 90 days after the date of the initial classification; Subsequent reclassification assessments shall be completed at 90-to 120-day intervals. And Special Reclassification Assessments requires, 'Staff shall complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (SMU), following an incident of abuse or victimization, and at any other time when warranted based upon the receipt of additional, relevant information, such as after a criminal act, or if a detainee wins a criminal appeal, is pardoned or new criminal information comes to light. If it is documented, suspected, or reported that a detainee has been physically or sexually abused or assaulted, the victim's perception of his or her own safety and well-being shall be among the factors considered." The Auditor's review of detention files found that detainees held at STIPC beyond 60 days received a reclassification and vulnerability reassessment every 60 days. The Auditor reviewed a detention file of a detainee who alleged sexual abuse which indicated this individual was provided the special assessment as required but six days after the allegation was made and not within 24 hours as required per the PBNDS.

DOES NOT MEET (e): The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The Auditor requires facility staff responsible for completing assessments for risk of victimization and abusiveness to receive refresher training on when an assessment is required per the PBNDS. The Auditor further requests to receive signed acknowledgments of staff completing the training and, if available, any reassessments completed based upon receiving additional, relevant information or following an incident of abuse or victimization conducted within the required time frame.

CORRECTIVE ACTION: The facility Compliance Administrator and acting PSAC Manager conducted refresher policy training on August 3-5, 2021, for staff responsible for completing the PREA Vulnerability Reassessment(s), reinforcing assessments are to be completed within 24 hours of receiving an allegation of sexual abuse. Training Attendance Records were provided for the Auditor's review. On December 13, 2021, the Auditor received three completed PREA Vulnerability Reassessments for detainees involved in sexual abuse allegations. These assessments were conducted on alleged victims and alleged abusers within 24 hours of the allegation in each case.

Additionally, based on new guidance from ERO, the 24-hour requirement in the PBNDS-2011 does not apply to the reassessment required following an incident of abuse or victimization. Based on this new guidance and previous misinterpretation, this provision is no longer a deficiency. The Auditor finds Standard 115.41 fully compliant in all material ways and the facility exceeds based on implementation of the 24-hour rescreening after an incident of sexual abuse which is beyond the requirements of this standard.

§115. Choose an item.

Outcome: Choose an item.

Notes:

§115. Choose an item.

Outcome: Choose an item.

Notes:

§115. Choose an item.

Outcome: Choose an item.

Notes:

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

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

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.

Tom Eisenschmidt December 25, 2021
Auditor's Signature & Date

(b) (6), (b) (7)(C) January 19, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) January 19, 2022
Program Manager's Signature & Date