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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Ron Kidwell	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(409) 866-(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:**	(409) 866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	San Diego Field Office		
Field Office Director:	Thomas Giles		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	880 Front Street, Suite 3200, San Diego, CA 92101		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	San Luis Regional Detention and Support Center (SLRDSC)		
Physical address:	406 N. Ave D, San Luis, AZ 85349		
Mailing address: *(if different from above)*	PO Box 7710 San Luis, AZ 85349		
Telephone number:	(928) 627-2101		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	David R. Rivas	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(928) 627-(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:**	(928) 627-(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.

During the audit, the Auditor found SLRDSC met 33 standards, had 2 standards (115.31, 115.32) that exceeded, had 1 standard (115.14) that was non-applicable, and 5 non-compliant standards (115.17, 115.21, 115.22, 115.65, 115.86). As a result of the facility being out of compliance with 5 standards, the facility entered into a 180-day corrective action period, which began on August 25, 2022, and ended on February 21, 2023. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

On September 21, 2022, the Auditor received notification of the facility's first CAP via email from the Office of Professional Responsibility's (OPR), External Reviews and Analysis Unit (ERAU) and reviewed the submission over the course of several days. Additional documentation and response were provided by the facility and reviewed by the Auditor on November 30, 2022; January 7, 2023; February 3, 2023; and February 7, 2023. At the conclusion of the CAP period, the Auditor determined that the facility demonstrated compliance with all five standards found non-compliant at the time of the site visit.

Number of Standards Met: 5

§115.17 Hiring and promotion decisions
§115.21 Evidence protocol and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.65 Coordinated response
§115.86 Sexual abuse incident reviews

PROVISIONS

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

§115. 17 - Hiring and promotion decisions

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

Notes:

(a)(b) SLRDSC Policy 2.11 states in part, "The Facility is prohibited from hiring anyone who may have contact with detainees, and shall not enlist the services of any contractor/volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity."

Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive that require collectively, to the extent permitted by law, prohibits hiring or promoting anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact with detainees, who: has 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); has been convicted 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 has been civilly or administratively adjudicated to have engaged in the activity as outlined above. Additionally, the acting Unit Chief of OPR Personnel Security Operations informed Auditors who attended virtual training in November 2021 about candidate suitability for all applicants to include 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.

SLRDSC Policy 2.11 states in part, "The Facility when considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. LSC, consistent with law, shall make its best effort to contact all prior institutional employers of any applicant for employment, to obtain information of substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse."

The Human Resource Manager (HRM) was interviewed and stated that the facility does not hire or promote anyone that has engaged in sexual abuse. The HRM stated that the facility acquires this information through written applications, criminal history checks, and making contact with prior institutional employers. The facility provided evidence that newly hired staff are asked the sexual misconduct questions during their background investigation when completing the New Hire Application. When asked if these questions were again asked or documented when considering promoting staff, the Assistant Warden (AW) stated that they were. However, the facility is not documenting that these misconduct questions are asked prior to staff promotions or during any annual review of current employees so the Auditor could not confirm the practice. The HRM indicated that when the new hire worked for another institutional employer, she would request any prior information regarding any sexual misconduct investigations involving that new hire. However, the SLRDSC did not make available any evidence that this practice is performed. The facility has not demonstrated that they have made best efforts to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse.

Does Not Meet (b): The facility has not provided any example or documentation as proof that the sexual misconduct questions are asked when considering the promotion of staff either in a written form, evaluations or during interviews. Additionally, these same misconduct questions must be asked in any written self-evaluations conducted as part of reviews of current employees. The facility has not shown or provided evidence that efforts are made to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse. The facility must also implement a procedure and practice of making their best effort to contact all prior institutional employers of an

applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. Once the facility has developed and implemented these procedures and processes, evidence of implementation of these procedures must be provided to the Auditor for compliance review. Samples of the misconduct questions being asked prior to the promotion of staff during the CAP period, if available, and in any written self-evaluations conducted as part of reviews of current employees must be provided to the Auditor for compliance review. Additionally, samples of attempts to contact prior institutional employers for new hires during the CAP period, if available, must be provided to the Auditor for compliance review.

Corrective Action (b): The SLRDSC provided a Memorandum from the Warden dated September 6, 2022, implementing new procedures for 115.17 Hiring and Promotion Decisions forms, PREA Employment Questions (misconduct & prior employers), New Hire Questionnaires 09-06-2022, and an email from the HR Manager advising all SLRDSC managers and supervisors of the new procedures. Additionally, the facility provided completed examples of two new employees recently hired using these forms. These documents were reviewed by the Auditor demonstrating that the facility has sufficiently implemented and documented the procedure of asking prospective employees about prior sexual misconduct prior to hiring, and current employees prior to promotion and during all employee evaluations. Additionally, these documents address the documenting prior institutional employers and information about attempts to contact those institutions. The Auditor accepted the CAP as partial compliance, pending receipt of at least one example of the completed misconduct questions for a promotion and five examples of completed misconduct questions completed during employee evaluations for compliance. On November 30, 2022, the Auditor again reviewed the facility's response. The SLRDSC provided five examples of employee evaluations being conducted and evidence that the questions associated with sexual misconduct were asked and documented in each evaluation. In addition, the SLRDSC also provided an example of one promotion where the candidate was also asked and documented the sexual misconduct questions. After review, the standard is now compliant.

§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:

(b) SLRDSC Policy 2.11 also states that, "The Warden shall consider how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victim's needs. The Facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. The facility shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified to victims of sexual assault of all ages. As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. A qualified agency staff member or a qualified community-based staff member means as individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals."

The SLRDSC provides the National Sexual Assault Hotline poster with contact information to the detainees housed at the facility. The SLRDSC also provided information for the only Rape Crisis Center (Amberly's Place) in Yuma, Arizona. The Auditor contacted the Amberly's Place Rape Crisis Center and spoke to the Director. The Director informed the Auditor that they do not, nor will they provide any advocacy to incarcerated individuals, including detainees housed at the SLRDSC. When calling the National Sexual Assault Hotline, the Auditor was told that they would assist the individual in getting in contact with the local rape crisis center. In this situation, the only local rape crisis center is not willing to provide the services associated with sexual abuse advocacy at the SLRDSC. The facility also provided a memorandum written by the Warden indicating that a community-based staff member was willing to provide the services of an advocate for sexual abuse victims at the SLRDSC. However, the Auditor has determined that the community-based staff member has not received the necessary training as outlined in this provision to provide those services at this time. The Assistant Warden (AW) informed the Auditor that the community-based staff member advised the AW that he did not currently possess the required training to provide rape crisis advocacy. When interviewing the Prevention of Sexual Assault (PSA) Compliance Manager, he indicated that they do provide detainee victim advocacy through the National Rape Crisis Hotline and that they have a community-based volunteer that is willing to be a sexual abuse advocate for the facility.

Does Not Meet (b): SLRDSC Policy 2.11 states in part that, "The Facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. A qualified agency staff member or a qualified community-based staff member means as individual who has received education concerning sexual assault and forensic examination issues in general. The outside or

internal victim advocate shall provide emotional support, crisis intervention, information, and referrals." The SLRDSC listed Amberly's Place through the National Rape Crisis Center as their rape crisis advocate. The Auditor contacted this advocacy center and spoke to the Director, who informed that the advocate will not provide crisis services to the SLRDSC. Therefore, the facility attempted to provide a community-based advocate to offer these services, but the community-based advocate has not received the appropriate training in accordance with provision (b) to qualify as a sexual abuse crisis advocate. The SLRDSC must provide victim services following incidents of sexual abuse. The facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If the rape crisis center is unable to provide these services, the agency shall provide these services by making available a qualified staff member from a community-based organization or a qualified agency staff member. Either of these individuals must receive education concerning sexual assault and forensic examination issues in general.

Corrective Action (b): On September 21, 2022, the Auditor accepted the CAP as presented by the SLRDSC for either a volunteer to receive appropriate training to become the designated rape crisis advocate or to enter into an MOU for these services to be provided by Amberly's Place. On January 7, 2023, the Auditor reviewed the documentation uploaded. The SLRDSC had provided communication through an email chain from the Compliance Manager through the Warden to an ICE official requesting assistance in obtaining a rape crisis advocate. The facility is recommending that ICE/ERO provide a qualified member to deliver victim services advocacy to the detainees held at their facility in accordance with NDS 2019, page 80. The email was dated December 6, 2022, with a response that ICE/ERO would be looking into providing this service. The Auditor was willing to accept this procedure when, and if, ICE/ERO agreed to provide this service for the facility. On February 3, 2023, the Auditor/APM reviewed the documentation uploaded on January 3, 2023. The email correspondence confirmed an anticipated future training completion which the Auditor/APM was willing to accept as partial compliance. The facility indicated there was an ICE ERO Memorandum forthcoming accepting responsibility for providing victim service to a victim of sexual abuse. On February 7, 2023, the Auditor/APM reviewed the documentation uploaded on February 7, 2023, consisting of a memorandum from the (A) Assistant Field Office Director (AFOD) accepting responsibility for providing victim advocacy services for victims of sexual abuse by a qualified party; additionally, Sure Helpline Center is scheduled to provide ICE ERO Sexual Assault Response Team training, on February 27, 2023, and conclude March 16, 2023, bringing ICE ERO up to the required standards. In addition, ICE ERO has provided a memorandum accepting responsibility to provide victim services to a victim of sexual abuse at the SLRDSC. The facility and ERO has sufficiently demonstrated compliance with provision (b) and the standard is now compliant.

§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:

(b)(d)(e)(f) SLRDSC Policy 2.11 also states, "Where sexual abuse is alleged, The Facility shall use investigators who are specially trained, qualified investigators in sexual abuse investigations and they must be prompt, thorough, objective, and fair. When possible and feasible, appropriate staff preserve the crime scene, and safeguard information and evidence in coordination with the referral agency and consistent with established evidence gathering and evidence processing procedures. SLRDSC shall ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for investigation by an agency with the legal authority to conduct criminal investigations and shall document such referrals. Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The agency shall maintain sexual abuse data collected for at least 5 years after the date of the initial collection unless Federal, State, or local law requires otherwise."

Policy 2.11 requires the Facility Administrator, PSA Compliance Manager, Facility Investigator, Corporate PREA Coordinator, and other designated individuals and the ICE AFOD or designee to be notified within two (2) hours of the occurrence. When a detainee(s) is alleged to be the perpetrator, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to the FOD, and/or designee, and the OPR JIC. All perpetrators of sexual abuse or assault shall be disciplined and referred for criminal prosecution as appropriate. When an employee, contractor or volunteer, inmate, prisoner, or detainee is alleged to be the perpetrator of detainee sexual abuse and/or assault, it is the facility administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to the FOD, and/or designee, who shall report it to the OPR JIC.
When the Facility Investigator was asked what external individuals or agencies the facility would report a sexual abuse allegation, he stated the JIC and the San Luis Police Department (SLPD). The AW indicated during his interview that the JIC, OPR, FOD, local law enforcement, and the LaSalle corporate office would be notified.

The AW indicated that when a sexual abuse allegation is made, the facility activates its Incident Command System (ICS) which indicates who and when all notifications must be made. Part of the ICS protocol is to make sure ICE is notified through email via Joint Intake Center (JIC) and the FOD. The PSA Compliance Manager stated that the facility would provide ICE with all the information needed regarding an alleged sexual abuse by a detainee. Finally, the investigative staff member reiterated the statements made by the PSA Compliance Manager. The Auditor reviewed one sexual abuse investigative file from 2019. This file indicated that ICE was notified regarding the allegation. In addition, information received from the Team Lead also indicates that ICE was notified about this case; however, no Joint Integrity Case Management System (JICMS) or Sexual Abuse and Assault Prevention and Intervention (SAAPI) number was assigned.

Does Not Meet (f): The facility has not demonstrated that ICE JICMS was notified of the one allegation that occurred during the audit period. Although the Auditor's review of the investigative file indicated all notifications were made, the allegation spreadsheet provided by the ERAU Team Lead indicated no JICMS or Sexual Abuse and Assault Prevention and Intervention Case Management (SAAPICM) number was issued which appears it was not reported to the Agency. However, an email from the Team Lead indicates that ICE ERO was notified by the facility, but ERO did not report the incident to JIC or SAAPI. To become compliant, the facility must establish procedures to ensure that all allegations are promptly reported to the agency as described in paragraphs (e) and (f) of this standard. Additionally, any new allegations that occur during the CAP period must be promptly reported to the agency according to these procedures and evidence must be provided to the Auditor for compliance review.

Corrective Action (f): The Auditor accepted the CAP as presented by the SLRDSC on September 8, 2022. The SLRDSC provided a Memorandum from the Warden dated September 6, 2022, indicating that the facility had developed a procedure to ensure that the FOD and OPR/JICMS is notified and that the JICMS or SAAPICM tracking number is captured on a new form that was created by SLRDSC. The Auditor accepted this corrective action as presented as partial compliance. To be fully compliant the facility needed to provide documentation of notification of an allegation occurring during the CAP period using the new procedures. On November 30, 2022, the Auditor reviewed the documentation uploaded from November 17, 2022. The SLRDSC provided comments stating that the likelihood of providing an example of making the appropriate notifications to ICE officials is unlikely during the CAP period, considering the last reported sexual abuse allegation received was in 2019. The Auditor accepted that fact at the conclusion of the CAP period. The facility is compliant with this standard.

§115. 65 - Coordinated response
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(c)(d) The SLRDSC policy does not directly outline or address specific procedures when a victim of sexual abuse is either transferred between facilities covered by 6 CFR part 115, subpart A or B, or to other facilities not covered by 6 CFR part 115, subpart A or B. There are no written procedures that govern if the SLRDSC can inform the receiving facility of the incident and the victims potential need for medical or social services. The AW was interviewed and asked what information would be provided to the receiving facility if SLRDSC transferred an alleged victim. The AW stated that the only information provided to the receiving facility would be by way of a medical transfer summary and that only the details of the alleged sexual abuse would be provided to ICE officials.

Does Not Meet (c)(d): The information conveyed by the AW and review of the documentation provided did not support any procedures in place for complying with these subparts. To become compliant with (c), the facility must have procedures in place to inform the receiving facility of a sexual abuse incident and the victim's potential need for medical or social services when a detainee victim is transferred between DHS immigration detention facilities. To become compliant with (d), the facility must have procedures in place to inform the receiving facility of a sexual abuse incident and the victim's potential need for medical or social services when a detainee is transferred to a facility not covered by paragraph (c) of this standard, unless the victim requests otherwise. These notifications must be documented and made available for compliance review.

Corrective Action (c)(d): On January 7, 2023, the Auditor reviewed the documentation uploaded on January 4, 2023. The SLRDSC provided their PREA Policy 2.11 which now contains the appropriate language that addresses subpart (c) and (d). After review, the Auditor accepted this action. The facility is compliant with this standard.

§115. 86 - Sexual abuse incident reviews
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c) SLRDSC Policy 2.11 states that, "the Facility Administrator will ensure staff conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or

investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The Warden shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the Field Office Director, for transmission to the ICE PSA Coordinator." The SLRDSC provided a memo dated April 19, 2022, signed by the Warden stating that "the SLRDSC has not received any complaints of sexual abuse from ICE detainees during this audit period. As a result, there has been no need to implement changes to policy or practice related to sexual abuse prevention. SLRDSC investigates all allegations of sexual abuse, and a sexual abuse incident review is conducted at the conclusion of each investigation." However, one allegation was reported within the audit period and the facility provided no documentation indicating an incident review was conducted. SLRDSC Policy 2.11 further states that, "the review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The Warden shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and Field Office Director or his or her designee, who shall transmit it to the ICE PSA Coordinator." The interview with the PSA Compliance Manager indicated that the incident review team looks at procedures, facts, and what may have contributed to the incident. He explained that the team consists of the PREA investigator, Warden, AW, and PREA Compliance Manager. The facility provided a blank sexual abuse incident review form that would be completed at the conclusion of every incident review. The document lists considerations such as race, ethnicity, LGBTQ, and gang affiliation. The interview with the AW indicated that an incident review would be conducted at the conclusion of every sexual abuse investigation. Furthermore, the AW indicated that the facility would conduct an annual review of all sexual abuse investigations and incident reviews to improve sexual abuse intervention, prevention, and response. The AW also indicated that the facility would prepare a negative annual report if the facility had not received any reports of sexual abuse.

Did Not Meet (a)(b)(c): The facility advised there were no allegations reported within the audit period; however, one investigation was conducted in 2019 on an allegation reported. The Auditor was provided no documentation to indicate an incident review was conducted. To become compliant, the facility must conduct an incident review of the allegation reported in 2019, meeting all requirements outlined in subpart (b) and provide documentation to the Auditor upon completion. The facility policy states that, "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 provided to the facility administrator and Field Office Director or his or her designee, who shall transmit it to the ICE PSA Coordinator." The facility has provided a negative report indicating no instances of sexual abuse during the prior 12 months audit period. However, the Auditor has received no evidence that the report has been provided to the FOD or the agency PSA Coordinator. The facility must send the negative report to the FOD and provide evidence that the documentation has been sent or received.

Corrective Action (a)(b)(c): The Auditor accepted the CAP as presented by the SLRDSC on September 21, 2022. The SLRDSC provided evidence of an Incident Review being conducted on the PREA allegation reported in 2019. The Facility also provided evidence that a "Negative Report" regarding reports of sexual abuse during the audit period had been forwarded to both the FOD and ERO PREA Field Coordinator. Therefore, the Auditor accepted the corrective action, and the facility is now compliant with all subparts of this standard.

Choose an item.

AUDITOR CERTIFICATION:

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

Ron Kidwell February 24, 2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) February 27, 2023

Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) February 28, 2023

Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	6/28/2022	**To:**	6/30/2022
AUDITOR INFORMATION			
Name of auditor:	Ron Kidwell	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	571-406-(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 Diego Field Office
Field Office Director:	Thomas Giles
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	880 Front Street, Suite 3200, San Diego, CA 92101
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:	San Luis Regional Detention and Support Center		
Physical address:	406 N. Ave D, San Luis, AZ 85349		
Mailing address: (if different from above)	PO Box 7710 San Luis, AZ 853349		
Telephone number:	(928) 627-2101		
Facility type:	IGSA		
PREA Incorporation Date:	8/2/2019		
Facility Leadership			
Name of Officer in Charge:	David R. Rivas	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(928) 627-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(928) 627-(b) (6), (b) (7)(C)

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

Click or tap here to enter text.

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the San Luis Regional Detention and Support Center (SLRDSC) operated by LaSalle Corrections Inc. was conducted on June 28-30, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Ron Kidwell, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant ICE Program Manager (APM), (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA Standards during the audit period of August 2, 2019, through June 30, 2022. This is the first DHS PREA audit conducted for SLRDSC.

SLRDSC is in San Luis, a city located on the southwest corner of the state which shares a U.S.-Mexico border in the county of Yuma, Arizona that has a population of 25,505. The Inter-governmental service agreement (IGSA) regarding the detention of ICE detainees is between the City of San Luis and DHS ICE. The facility's housing capacity is 870. DHS ICE contracts with SLRDSC to hold up to 150 male and female detainees. The facility also holds a contract with the United States Marshal Service (USMS) to provide detention for 550 prisoners. At the time of the on-site audit the facility's ICE detainee population was one. At this facility, ICE detainees are housed separate from the USMS prisoners. The detainees wear blue jumpsuits to help identify those that are ICE detainees from the USMS prisoners who wear orange jumpsuits. The SLRDSC further separates detainees by where they will be transported to in the near future. The Assistant Warden (AW) explained to the Auditor that the facility receives somewhere between 70 to 120 ICE detainees at any given time approximately once a week. Then the entire ICE detainee population will be transported to other locations in both Arizona and California every Sunday. The only detainees not transported are those that test positive for COVID-19. The SLRDSC reported that they do not accept or hold any juvenile ICE detainees. The facility consists of two one-story, connected buildings, surrounded by a security fencing perimeter with a secure Sallyport. The original facility was constructed in 2007 and the expansion to the facility was added in 2011. Building 1 consists of 18 dorms and medical which includes both medical isolation rooms and medical observation rooms. Building 2 consists of 15 dorms. The entire facility is monitored by one control center which is always staffed with two officers; the facility has a secondary control center, but it is not currently staffed. (b) (7)(E)

Team Lead (b) (6), (b) (7)(C) from OPR ERAU provided the completed Pre-Audit Questionnaire (PAQ), along with supporting documents and policies for the SLRDSC on the secure ERAU SharePoint website approximately two weeks prior to the on-site phase of the audit. The provided information included policies, memorandums of understanding (MOUs), training records and curricula, facility schematics, and a multitude of other related documentation and materials to used determine compliance with the DHS PREA standards.

The Auditor completed the review of all documentation that was provided by the Team Lead and SLRDSC in the FY22 Facility Document folder prior to the site visit. On June 17, 2022, the Auditor emailed the OPR Personnel Security Office (PSO) and Team Lead with a background clearance form that listed two ICE Enforcement and Removal Operations (ERO) officers, seven LaSalle officers, and two LaSalle contractors. The Auditor also identified possible gaps or issues that needed to be followed up on and in some cases requested additional information. The request was captured on an easy to review document called an Issue Log. The log is used to outline requests for response to questions that need to be clarified during the audit process. The Auditor submitted his Issue Log to the Team Lead on June 21, 2022, containing 11 requests for additional information. This information was provided to the Auditor during the on-site phase and all requests were met. Finally, on June 23, 2022, the Auditor submitted an email containing the notification to detainee of PREA investigation form to the Team Lead requesting information regarding a 2019 alleged PREA administrative investigation.

On June 20, 2022, the Auditor contacted the victim advocacy group that the SLRDSC had identified as their victim advocate. Amberly's Place is the only advocacy rape crisis center located in Yuma, AZ that provides services for victims of domestic violence, child abuse, sexual assault, and elder abuse. When conducting an interview with the Director, she informed the Auditor that they would not contract to provide advocacy to any detention facility due to their contractual mission and that her agency would be incapable of providing any continuing counseling to detainees. Yuma Medical Center does not employ SANE or SAFE nurses, but contracts with trained SANE nurses from Amberly's place for forensic medical examinations (FME) as needed. The Director of Amberly's Place stated that if requested by law enforcement her organization would conduct a forensic medical examination regarding any ICE detainee that had alleged a sexual assault.

On June 28, 2022, at approximately 8:00 a.m., the Auditor met with facility staff and proceeded to the Training Room where the in-briefing was conducted by the Auditor and ERAU Team Lead (b) (6), (b) (7)(C) via teleconference call. Those in attendance were:

(b) (6), (b) (7)(C) ICE/ERO, Deportation Officer (DO)
(b) (6), (b) (7)(C) ICE/ERO, DO
David Rivas, SLRDSC, Warden

(b) (6), (b) (7)(C) SLRDSC Assistant Warden (AW), Officer in Charge (OIC)
(b) (6), (b) (7)(C) SLRDSC Prevention of Sexual Assault (PSA) Compliance Manager
(b) (6), (b) (7)(C) SLRDSC Human Resources Manager (HRM)
(b) (6), (b) (7)(C) SLRDSC Operations Sergeant
(b) (6), (b) (7)(C) SLRDSC Training Manager
(b) (6), (b) (7)(C) SLRDSC Health Services Administrator (HSA)
(b) (6), (b) (7)(C) SLRDSC Operations Lieutenant
(b) (6), (b) (7)(C) SLRDSC Transportation Lieutenant
(b) (6), (b) (7)(C) SLRDSC Business Manager
(b) (6), (b) (7)(C) ICE/OPR/ERAU Inspections and Compliance Specialist
Ron Kidwell, Certified DOJ/DHS Auditor, Creative Corrections, LLC

The meeting was designed to create a positive working relationship, place names with faces, and prepare for the next three days. Shortly after the conclusion of the meeting, the Auditor began the facility tour accompanied by the AW, PSA Compliance Manager, and two DOs. The tour covered the entire facility over the next two hours. The Auditor observed 33 housing dorms, a booking/intake center, classroom, law library, medical isolation and observation rooms, recreation yard, sallyport, laundry room, kitchen, storage rooms, control rooms, special management unit, restricted housing unit, and visitation. During the tour, the Auditor looked at camera placements for possible blind spots and detainee to officer ratio in accordance with the housing dorms capacity occupancy. The Auditor looked at how the toilets and shower areas were configured and if detainees are able to change clothes, shower, and use the restroom without being viewed by opposite-gender staff. The Auditor documented that DHS ICE Zero Tolerance for Sexual Abuse posters with phone and other contact information and PREA Audit Notices were displayed in plain sight.

PREA Audit Notices in English and 11 other languages were sent to the SLRDSC prior to the on-site visit. The PREA Audit Notice communicates to staff and detainees that the facility will be undergoing an audit for compliance with DHS/ICE standards to prevent, detect, and respond to sexual abuse in a confinement setting. The notice also spells out how confidential information is to be handled and where that confidential information can be reported. The Auditor did not receive any correspondences from either staff, or ICE detainees. The Auditor noted the number of phones in each housing dorm and that the advocacy information along with the outside reporting entity contact information was readily available in the housing areas. The Auditor also conducted a test call to the outside entity which was the DHS Office of the Inspector General (OIG) in an attempt to prove the effectiveness of the facility's practice. Finally, the Auditor did not observe the processing of any ICE detainee but did have an Intake Officer walk through the intake and classification process and observed the computer-generated documentation that is captured during those processes. The opportunity to witness the processing of an ICE detainee did not present itself during the Auditor's time at the on-site audit.

Immediately following the facility tour, the Auditor interviewed staff as well as the only ICE detainee at the facility. Staff interviews were conducted in the training room in private. During the interview process, 12 random staff were interviewed. The staff were randomly selected by the Auditor using the daily duty roster provided by the PSA Compliance Manager. The Auditor chose staff from both day and night shifts, working different assignments, and with different levels of experience. The Auditor also made sure interviews were conducted with the appropriate number of female staff that corresponded with the daily duty roster. The Auditor also conducted 14 specialized staff interviews. This process continued over the next two days. Over the three-day period, the Auditor conducted 26 interviews with security staff, 3 contractors, 2 volunteers, and one detainee. Listed below are the specialized staff positions that were interviewed: 1 Assistant Warden, 1 PSA Compliance Manager, 1 Administrative Human Resources Manager, 1 Investigative Staff, 3 Medical and Mental Health Care Staff, 1 Training Supervisor, 1 Grievance Coordinator, 1 Intake Staff, 1 First Line Supervisor, 1 Classification Officer, and 2 volunteers.

The selection of specialized staff also included several individuals who held multiple roles and responsibilities covered by the protocols. For example, the PSA Compliance Manager is also responsible for monitoring retaliation and the AW is part of the Incident Review Team.

During the audit, one ICE detainee was interviewed using both the random sample of detainees and detainees who are limited English proficient (LEP) protocols. The Auditor utilized the Creative Corrections language services line to perform the interview with the assistance of an interpreter because the detainee spoke Mandarin.

The Auditor requested that the PSA Compliance Manager provide a predetermined list of investigations, detainee files, and employee files selected by the Auditor. Those files consisted of 11 detainee files to include the one detainee that was interviewed, the 12 random staff employee files that were interviewed, and 1 investigative file that had been identified from 2019.

There was one allegation of sexual abuse reported during the audit period as a detainee-on-detainee allegation. Based on the review of the Allegations Spreadsheet, and the investigation itself, the final disposition was unsubstantiated. Lastly, the San Luis Police Department (SLPD) was notified and determined no probable cause existed that a crime was committed given the nature of the allegation; therefore, they declined to investigate. An administrative investigation was conducted by the facility. The ICE ERO was promptly notified of this incident.

The facility provided two governing policies related to and covering procedures for their Sexual Abuse and Assault Prevention and Intervention (SAAPI) program which are part of the SLRDSC Policy Procedures Manual: Policy SLRDSC 2.11, DHS/PREA; and Policy

SLRDSC 2.9.1, Restrictive Housing Units Operations. These policies will be referenced throughout this report as SLRDSC Policy 2.11 and SLRDSC Policy 2.9.1.

On Thursday, June 30, 2022, an exit briefing was held at approximately 1:30 p.m. in the Training Room to discuss the audit findings. ERAU Team Lead (b) (6), (b) (7)(C) opened the meeting and then turned it over to the Auditor for an overview of the findings. The following individuals were in attendance:

(b) (6), (b) (7)(C) SLRDSC AW, OIC
(b) (6), (b) (7)(C) SLRDSC PSA Compliance Manager
(b) (6), (b) (7)(C) SLRDSC HRM
(b) (6), (b) (7)(C) SLRDSC Training Manager
(b) (6), (b) (7)(C) SLRDSC HSA
(b) (6), (b) (7)(C) SLRDSC Operations Lieutenant
(b) (6), (b) (7)(C) SLRDSC Transportation Lieutenant
(b) (6), (b) (7)(C) SLRDSC Operations Lieutenant
(b) (6), (b) (7)(C) SLRDSC Officer
(b) (6), (b) (7)(C) SLRDSC Officer
(b) (6), (b) (7)(C) SLRDSC Officer
(b) (6), (b) (7)(C) SLRDSC Officer
(b) (6), (b) (7)(C) SLRDSC Officer
(b) (6), (b) (7)(C) SLRDSC Officer
(b) (6), (b) (7)(C) SLRDSC Officer
(b) (6), (b) (7)(C) SLRDSC Mail Clerk
(b) (6), (b) (7)(C), SLRDSC Kitchen Manager
(b) (6), (b) (7)(C) SLRDSC Human Resources Assistant
(b) (6), (b) (7)(C) SLRDSC Business Manager
(b) (6), (b) (7)(C) ICE/OPR/ERAU Inspections and Compliance Specialist (via teleconference)
Ron Kidwell, Certified DOJ/DHS Auditor, Creative Corrections, LLC

The Auditor thanked everyone present and the entire staff at the SLRDSC for their cooperation, professionalism, and hospitality during the audit. The Auditor reported that the facility had not provided a victim advocate that meets the criteria outlined in DHS PREA Standard 115.21. The Auditor advised those in attendance that he would be unable to provide them with the audit findings until performing a triangulation of all information collected (policy, interviews, observations) to determine if each standard is met before making a final decision.

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
§115.31 Employee, contractor, and volunteer training
§115.32 Other Training

Number of Standards Met: 33
§115.11 Zero-tolerance of sexual abuse
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.18 Upgrades to facilities and technologies
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and mental health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of Assessment Information
§115.43 Protective Custody
§115.51 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
§115.66 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 screening; history of sexual abuse
§115.82 Access to emergency medical services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 5
§115.17 Hiring and promotion decisions
§115.21 Evidence protocol and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.65 Coordinated response
§115.86 Sexual abuse incident reviews

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

PROVISIONS

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

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

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

Notes:

(c) SLRDSC Policy 2.11 is the facility's written SAAPI policy that states in part, "It is the policy of the LaSalle Corrections (LSC) to establish effective procedures that ensures the safety and well-being to all staff and detainees. All staff will be trained to identify and subsequently prevent sexually abusive behavior among detainees housed at this facility. LSC maintains a zero-tolerance policy for all forms of sexual abuse or sexual harassment in compliance with applicable standards including National Standards to Prevent, Detect, and Respond to Prison Rape under the Prison Rape Elimination act; measures are taken to prevent sexual abuse or assault, including the designation of specific staff members responsible for staff training and detainees education regarding issues pertaining to sexual assault; procedures for immediate reporting of any allegations of sexual abuse or assault through LSC's chain of command procedures, and to ICE/ERO including written documentation requirements; procedures for detainees to report allegations; measures taken for prompt and effective intervention to address the safety and medical/mental health treatment needs of detainee victims, and to preserve and collect evidence; procedures for referral of incidents to appropriate investigative law enforcement agencies and OPR, and coordination with such entities; disciplinary sanctions for staff, up to and including termination when staff has violated agency sexual abuse policy; and data collection and reporting." At the conclusion of SLRDSC Policy 2.11 is a review signature page that contains both the Facility Administrator's signature and the ICE Assistant Field Officer's (AFOD) signature acknowledging the review of policy 2.11 dated June 1, 2022.

(d) SLRDSC Policy 2.11 states in part that, "The Facility Administrator will designate a Prevention of Sexual Assault Compliance Manager POC for ICE and [...] PSA Coordinator who will serve as the facility point of contact for the ICE PSA Coordinator and who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. The Compliance Manager shall: a) assist with the development of written policies and procedures for the Sexual Abuse and Assault Prevention and Intervention Program, as specified above in this standard, and with keeping them current; b) assist with the development of initial and ongoing training protocols; c) serve as a liaison with other agencies; d) Coordinate the gathering of statistics and reports on incidents of sexual abuse or assault; e) review the results of every investigation of sexual abuse and assist in conducting an annual review of all investigations in compliance with the Privacy Act to assess and improve prevention and response efforts; and f) Review facility practices to ensure required levels of confidentiality are maintained. Medical staff shall be trained in procedures for examining and treating victims of sexual abuse, in facilities where medical staff may be assigned these activities. This training shall be subject to the review and approval of the Field Office Director or other designated ICE official." The PSA Compliance Manager confirmed during his interview that he is the facility's point of contact for the ICE PSA Compliance Manager and stated that he has sufficient time and authority to oversee the facility's efforts to comply with facility sexual abuse prevention and intervention policies and procedures. The PSA Compliance Manager also stated that he answers directly to the Warden. This was confirmed through the organizational chart that was provided by the facility.

§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) SLRDSC Policy 2.11 states in part, "The Facility will maintain sufficient supervision of detainees through a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect detainees against sexual abuse." The Auditor observed camera placement and entered each control room where video monitoring was being conducted. (b) (7)(E) [redacted] When interviewing the AW and PSA Compliance Manager, they indicated that the facility maintains sufficient supervision of detainees to protect against sexual abuse by conducting post checks, and video monitoring. The AW also stated that they run their staffing plan based on population and that at no time would the officer to detainee ratio be more than 1 officer to 48 detainees.

(b) The SLRDSC provided post orders for each post that outlines the supervision responsibilities regarding ICE detainees. The post orders direct security staff under "special instructions" not to leave ICE detainees unattended, that ICE detainees are never allowed to intermingle with U.S. Marshal prisoners, conduct security checks of detainees every 30 minutes in irregular intervals, monitor detainee activities within the housing unit dayroom areas, and other instructions associated with each specific security post. The post orders are reviewed and signed off on annually by the AW. The current post order signature page indicated that the AW signed off on the post orders in January of 2022. The AW was asked how the facility determines and maintains appropriate staffing levels. The AW explained that the staffing plan is based on the capacity inmate/detainee population plan that has been pre-determined as to the detainee to officer ratio.

(c) SLRDSC Policy 2.11 states in part, "In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration: Generally accepted detention and correctional practices; Any judicial findings of inadequacy; Any findings of inadequacy from Federal investigative agencies; Any findings of inadequacy from internal or external oversight bodies; All components of the facility's physical plant (including "blind-spots" or areas where staff or inmates may be isolated); The composition of the inmate population; The number and placement of supervisory staff; Institution programs occurring on a particular shift; Any applicable State or local laws, regulations, or standards; The prevalence of substantiated and unsubstantiated incidents of sexual abuse." When the AW was asked how the facility takes into account each of the above listed factors, the AW indicated that there have been no judicial findings, the physical layout of the facility has not changed, and they review any substantiated or unsubstantiated incidents of sexual abuse to determine if there was any lack of supervision that may have contributed to the incident. The AW further stated that he would consider all recommendations made by the Incident Review Team and the length of time detainees spend in facility custody. The Auditor reviewed one alleged sexual abuse incident from 2019. This incident is a sexual harassment allegation involving two female detainees. An investigation was conducted, and the case findings were unsubstantiated. The Auditor did not review the Incident Review regarding this case from 2019, because as indicated in 115.86, the facility did not provide proof an incident review was completed.

(d) SLRDSC Policy 2.11 states in part, "The Chief of security shall ensure the Shift Supervisor or designee is conducting weekly rounds and documenting PREA unannounced rounds. Both day and evening shift supervisors, while conducting these rounds shall be looking at cross-gender viewing, gender announcement, staff-detainee communication, identify and deter sexual abuse of detainees and ensuring PREA signs are posted in housing areas and holding rooms. Employees are prohibited from alerting other employees that these supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the Facility." The facility provided activity logs from both day and night work that document unannounced rounds at different times of the day by the on-duty supervisor. This is accomplished by documenting the supervisor's signature, date and time, and a brief statement indicating the PREA unannounced round. Also, during the on-site facility tour the Auditor physically witnessed these activity logs with the necessary documentation. Documents provided by the facility also show multiple checks during each shift. Finally, when conducting an interview with a first line supervisor, he indicated that unannounced rounds must be conducted on every post twice a shift, that the rounds must be at different times of the day and documented in red ink in each activity log. The Auditor observed and obtained evidence that the practice is to conduct two unannounced rounds on each post per shift even though the policy states that it is only required weekly.

Recommendation (d): The Auditor recommends that SLRDSC Policy 2.11 be updated to include the actual practice of two unannounced rounds on each post per shift, since the policy as written would not have met the DHS PREA standard without the Auditor's verification of practice. Specifically, 115.13(d) requires, "Each facility shall conduct frequent unannounced security inspections identify and deter sexual abuse of detainees. Such inspections shall be implemented for night as well as day shifts."

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b)(c)(d) SLRDSC Policy 2.11 states in part that, "A youthful inmate shall not be placed in a housing unit that have sight, sound, and physical contact separation from adult detainees. In areas other than housing units, sight and sound separation shall be maintained between youthful detainees unless the Facility can provide direct Employee supervision over detainees in the area. LSC shall not use isolation or denial of exercise, education, or other program, work opportunities in order to comply with these requirements. In the event the facility receives a youthful detainee who is determined to be a juvenile during the intake process. The youthful detainee will not be placed in housing units with adults, the detainee will be placed in Medical and ensure that the detainee does have sight, sound, or physical contact with an adult detainee. The facility will notify the AFOD so the youthful detainee can be transported to an appropriate facility."

The completed PAQ indicates no juvenile detainees have been held at SLRDSC within the audit period, and during conversations with staff and the AW, they confirmed that the facility does not house or accept juvenile ICE detainees. During the on-site portion of this audit, there was no indication or evidence that juvenile detainees are housed at this facility. During the policy and document review, the facility created a memo dated April 6, 2022, for the Auditor from the Warden stating that the facility does not house juvenile detainees or families; therefore, this standard is not applicable.

§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) SLRDSC Policy 2.11 states in part, "The Facility shall not conduct cross-gender pat-down searches of male detainees unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. The Facility shall not conduct cross-gender pat-down searches of female detainees unless in exigent circumstances." The Auditor interviewed 12 random staff members. Seven staff members were male officers who was asked if they had ever witnessed a female officer conduct a pat search of a male detainee or if they had conducted a pat search on a female detainee. All seven officers stated "no" to both questions. In addition, when five female officers were asked if they had ever witnessed a male officer conduct a pat search on a female detainee or if they had conducted a pat search on a male detainee, all five female officers stated "no" to both questions.

(d)(f) SLRDSC Policy 2.11 states in part, "The Facility shall document all cross-gender strip searches, cross-gender visual body cavity searches, and all cross-gender pat-down searches." The facility provided a memorandum for record indicating there had been no instances during the audit period where SLRDSC staff had conducted a cross-gender pat-down search. They also provided a blank copy of a Critical Incident report form for which the cross-gender pat down search would be documented, if it had occurred. When interviewing random staff, they all indicated that they had never experienced a situation where there was a need or exigent circumstance to search a detainee of the opposite gender. However, they reported if an incident occurred it would be immediately documented. The facility provided a memorandum for record indicating there had been no instances during the audit period where SLRDSC staff had conducted a cross-gender strip searches or body cavity searches. The Auditor confirmed during random staff interviews their knowledge that the search would have to be documented.

(e) SLRDSC Policy 2.11 states in part, "The Facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances including consideration of officer safety, or when performed by medical practitioners." During the interview process of 12 random staff, seven male and five female were asked if they had ever performed or witnessed a strip search or body cavity search of either a male or female detainees. All 12 security officers stated "no" regarding any strip search or body cavity search being conducted on any ICE detainees. The Medical Health staff member indicated that medical staff would not perform either a strip search or body cavity search. If a body cavity search were necessary, that detainee would be sent out to the local hospital for the search to be conducted. The facility does not accept or house juvenile ICE detainees.

(g) SLRDSC Policy 2.11 states in part, "The Facility shall enable detainees to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine dorm checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. The Facility shall require staff of the opposite gender to announce their presence when entering a detainee-housing unit." During the on-site facility tour, the Auditor witnessed the dormitory bathroom layout which included full length shower curtains, half wall partitions, and curtains on the windows that can be drawn or opened from the outside hallway. The Auditor also observed security staff making opposite gender announcements prior to entering a dorm of the opposite gender. (b) (7)(E) [redacted] No cameras are placed in the dorms or cells. The Auditor interviewed 12 (7-male/5-female) random security staff members and asked what steps are taken to allow detainees to privately shower, use the restroom, and change clothes. From those interviews all 12 officers indicated they would announce themselves prior to entering the space where detainees are permitted to be in a state of undress. Two officers stated that a female officer clears the dorm prior to any male officer entering. Four officers mentioned that the curtains on the windows provide additional privacy for detainees to change clothes.

(h) This facility is not a Family Residential Facility; therefore, this provision is not applicable.

(i) SLRDSC Policy 2.11 states in part, "The Facility shall not search or physically examine a transgender or intersex detainee for the sole purpose of determining the detainee genital status. If the detainee's genital status is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of the standard medical examination that all detainees must undergo as part of the intake or other processing procedures conducted in private by a medical practitioner." Random staff were asked if they had ever conducted or witnessed a search or physical examination to determine a detainee's gender and all 12 random security staff interviewed indicated that they had not conducted or witnessed such a search. The AW confirmed during his interview there were no searches conducted of detainees to determine a detainee's gender during the audit period.

(j) SLRDSC Policy 2.11 states in part, "The Facility shall train security staff in how 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 possible, consistent with security needs." When conducting interviews with random security staff, all indicated that they had been trained on how to conduct cross-gender pat-down searches in a professional and respectful manner. Officers stated that they would use the quadrant method utilizing the back or blade of their hand. They indicated that they would inform the detainee of what was going to happen during the search so that the detainee is aware; several officers referred to having the detainee pull the clothing away from their body to possibly shake any contraband loose. The training supervisor was asked if security staff is trained in the proper procedures for conducting pat-down searches, including cross-gender and transgender pat-down searches and he confirmed that all officers are trained in this procedure. The Intake Officer was interviewed and indicated that the facility has a form that asks a transgender or intersex detainee who they want to be searched by, where they want to be housed, and how they identify. The facility provided a training curriculum provided by the National PREA Resource Center developed by the Moss Group titled "Guidance in Cross-Gender and Transgender Pat Searches" and the 2022 Correctional Officer Training Curriculum that includes training on "Guidance in Cross-Gender and Transgender Pat Searches." Both instructional programs meet the requirements of this standard. The 12 random security staff confirmed watching the Cross-Gender and Transgender Pat searches video as part of the facility's annual PREA training.

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

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

Notes:

(a) SLRDC Policy 2.11 states in part that, "The Facility shall take appropriate steps to ensure that detainees with disabilities (including detainees who are deaf or hard of hearing those who are blind or have low vision, or those who have intellectual, psychiatric, or

speech disabilities) have an opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Also providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication." The facility plays a PREA educational video that has closed caption for detainees that may be hearing impaired, and the video has audio in both English and Spanish for those detainees that may be visually impaired. Policy 2.11 states, "Where practicable, provisions for written translation of materials related to sexual abuse or assaults shall be made for any significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." Both the Intake Officer and Classification Officer informed the Auditor that a TTY is available and if needed, arrangements can be made through their language line services contract to provide sign language assistance. When conducting interviews with 12 random staff members, they were asked if they had ever encountered a detainee that was blind, deaf, or intellectually disabled. They all stated "no." When asked how they would provide that information the random staff interviewed indicated that deaf detainees could read the closed caption video, or they could arrange for a sign language interpreter. When discussing blind detainees, the staff indicated through the audio of the video, or they could read the information to them. Finally, regarding those detainees that were intellectually disabled, the random staff indicated they would contact the medical section for assistance and that it depended on the detainee's level of comprehension if they could read the information in a manner that the detainee could understand. The facility has the ability to translate the SLRDSC Handbook utilizing computer software in any language that is nationally recognized. The AW was interviewed and asked if the facility had ever been unable to accommodate a detainee with a disability and he confirmed that the facility had not experienced a detainee with a special need requiring accommodations.

(b)(c) SLRDSC Policy 2.11 states in part, "The Facility shall employ effective and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. Each facility shall provide detainees with disabilities and detainees with [limited English proficiency (LEP)] with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. When practicable, provisions for written translation of materials related to sexual abuse or assault shall be made for other significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate."

The SLRDSC Handbook is provided in English and Spanish, and the facility has the capability of translating their handbook in many other languages using an interpretation platform on the internet. Then the SLRDSC Handbook is printed and provided to the detainee. This is how the LEP detainee that was interviewed was provided an SLRDSC Handbook in Mandarin. The facility indicated on the PAQ that the top three nationalities of facility population is European, Central America, and Hindi. The Auditor reviewed the SLRDSC Handbook in English and observed the explanation of methods for reporting sexual abuse, prohibition against retaliation, and the right of a detainee that has been subjected to sexual abuse to receive treatment and counseling. The SLRDSC Handbook provides the contact information for the DHS OIG as the outside entity reporting agency regarding allegations of sexual abuse. There is information present in the SLRDSC Handbook that addresses prevention and intervention strategies, definition and examples of detainee-on-detainee sexual abuse, staff on detainee sexual abuse, or coercive sexual activity. Finally, there is information about self-protection and indicators of sexual abuse. During the on-site review, the Auditor observed the ICE Zero-Tolerance poster and the ICE Detention Reporting and Information Line (DRIL) poster placed on the perimeter walls of the housing dorms. These posters state the "Report Sexual Assault Now" message in six languages other than English and Spanish.

The PREA video shown during intake, is displayed in both English and Spanish. The Auditor received and observed evidence that the SLRDSC makes available to the detainees the ICE National Detainee Handbooks, which are available in 14 languages (English, Spanish, Bengali, French, Haitian Creole, Punjabi, Hindi, Arabic, Chinese, Romanian, Turkish, Russian, Portuguese, and Vietnamese), and the DHS-prescribed Sexual Abuse and Assault Awareness (SAA) information pamphlets, which are available in 9 languages (Arabic, English, French, Haitian Creole, Chinese, Hindi, Portuguese, Punjabi, and Spanish). The intake officer confirmed that all detainees receive both the facility and ICE National Detainee Handbook and that all detainees are required to view the educational video before being transferred to their housing assignment. All this takes place in the intake area. The facility has demonstrated that they ensure meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse, for those who speak languages other than English.

The AW was interviewed and asked if his facility has established procedures to provide detainees with disabilities and detainees who are LEP the ability to participate in or benefit from all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The AW stated that his staff has access to the ERO Language Services Resource Flyer, and the majority of his staff are bi-lingual, mostly Spanish speaking. The ERO Language Services Resource Flyer provides access to a website and a 24-hour language line for translation and interpretation services. He indicated that his staff is aware of the services available for those detainees that need assistance. Of the 12 security officers interviewed, all confirmed that the facility does not utilize detainee interpreters, unless the detainee requests the use of another detainee for interpretation, and the facility determines this is appropriate and meets policy guidelines. However, all 12 random staff members indicated that they would not allow a detainee to interpret regarding a sexual abuse report. Both the AW and PSA Compliance Manager confirmed this practice during their interviews. Staff assigned to intake are able to use the language line services. Any other requests must be approved by a supervisor. The one detainee interviewed was LEP.

Through the assistance of an interpreter using a language line service, the detainee explained that when he first arrived at the facility staff used an interpreter service to communicate with him. He also stated that they provided him with an SLRDSC Handbook in a language (Mandarin) he could understand. The detainee also acknowledged the PREA posters mounted to the dorm wall.

§115.17 – Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) SLRDSC Policy 2.11 states in part, "The Facility is prohibited from hiring anyone who may have contact with detainees, and shall not enlist the services of any contractor/volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity."

Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive that require collectively, to the extent permitted by law, prohibits hiring or promoting anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact with detainees, who: has 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); has been convicted 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 has been civilly or administratively adjudicated to have engaged in the activity as outlined above. Additionally, the acting Unit Chief of OPR PSO informed Auditors who attended virtual training in November 2021, about candidate suitability for all applicants to include 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.

SLRDSC Policy 2.11 states in part, "The Facility when considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. LSC, consistent with law, shall make its best effort to contact all prior institutional employers of any applicant for employment, to obtain information of substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse."

The HRM was interviewed and stated that the facility does not hire or promote anyone that has engaged in sexual abuse. The HRM stated that the facility acquires this information through written applications, criminal history checks, and making contact with prior institutional employers. The facility provided evidence that newly hired staff are asked the sexual misconduct questions during their background investigation when completing the New Hire Application. When asked if these questions were again asked or documented when considering promoting staff, the AW stated that they were. However, the facility is not documenting that these misconduct questions are asked prior to staff promotions or during any annual review of current employees so the Auditor could not confirm the practice. The HRM indicated that when the new hire worked for another institutional employer, she would request any prior information regarding any sexual misconduct investigations involving that new hire. However, the SLRDSC did not make available any evidence that this practice is performed. The facility has not demonstrated that they have made best efforts to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse.

Does Not Meet (b): The facility has not provided any example or documentation as proof that the sexual misconduct questions are asked when considering the promotion of staff either in a written form, evaluations or during interviews. Additionally, these same misconduct questions must be asked in any written self-evaluations conducted as part of reviews of current employees. The facility has not shown or provided evidence that efforts are made to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse. The facility must also implement a procedure and practice of making their best effort to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. Once the facility has developed and implemented these procedures and processes, evidence of implementation of these procedures must be provided to the Auditor for compliance review. Samples of the misconduct questions being asked prior to the promotion of staff during the CAP period, if available, and in any written self-evaluations conducted as part of reviews of current employees must be provided to the Auditor for compliance review. Additionally, samples of attempts to contact prior institutional employers for new hires during the CAP period, if available, must be provided to the Auditor for compliance review.

(c)(d)(e)(f) SLRDSC Policy 2.11 states in part, "The Facility shall conduct criminal background checks and make its best effort to contact prior institutional employers to obtain information on substantiated allegations of Sexual Abuse or any resignation pending investigation of an allegation of Sexual Abuse, prior to hiring new Employees. Background checks shall be repeated for all Employees, Contractors, and Volunteers at least every five years. The Facility shall also impose upon Employees a continuing affirmative duty to disclose any such conduct. Material omissions regarding such misconduct, or the provision of materially false information, shall be

grounds for termination. Unless prohibited by law, the Facility shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work."

The Auditor conducted a file review on 12 randomly selected individuals including civilian staff, contractors, and security staff. All 12 files indicated an initial and five-year criminal history check was conducted. Additionally, the Auditor submitted a Background Investigation for Employees and Contractors form to the OPR PSO prior to the site visit requesting verification of background investigations on two ERO officers assigned to the SLRDSC. The PSO responded via email confirming the ERO officers were current on their initial and five-year background investigations. The HRM further stated during her interview that if a new hire provided false information or omitted certain material then the facility would rescind the offer letter. Finally, the HRM indicated that any inquiries into prior employees by other institutional employers would be granted if the requesting agency provided a signed release from the applicant.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a)(b) SLRDSC Policy 2.11 states in part, "The Facility shall consider the effect any (new and upgrade) design, acquisition, expansion or modification of physical plant or monitoring technology might have on the Facility's ability to protect individuals in a LaSalle Corrections Facility from Sexual Abuse."

The SLRDC reported no completion of any substantial expansion or modification of the existing facility within the audit period on the PAQ. The SLRDSC also provided a memorandum dated April 6, 2022, signed by the Warden, explaining the facility had not made any substantial expansions or modifications to the existing facility since August 20, 2012. This was further confirmed during interviews with the AW and PSA Compliance Manager.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) SLRDSC Policy 2.11 states that, "The Warden is responsible for investigating allegations of sexual abuse; LSC shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable."

The SLRDSC provided a Memorandum of Understanding (MOU) between the SLRDSC, and the SLPD dated June 16, 2022, signed by the Warden, Chief of Police, and City Manager. The policy specifies that the SLPD conduct all criminal sexual assault investigations and use a uniform evidence protocol in coordination with DHS that is developmentally appropriate for juveniles. SLRDSC Policy 2.11 has been reviewed and approved by the ICE AFOD.

When interviewing the PSA Compliance Manager, he was asked if the facility uses a uniform evidence protocol and he confirmed that they do. He stated that the facility's main responsibility is to preserve the evidence until the SLPD arrives to collect all physical evidence. The protocol includes securing the scene and requesting the alleged victim not brush their teeth, change clothes, take a shower, or use the restroom. It also includes ensuring the alleged perpetrator not brush their teeth, change clothes, take a shower, or use the restroom. The Auditor spoke with a sex crime detective with SLPD. The detective provided the Auditor with the agency's nineteen-page Standard Operating Procedure uniform evidence protocol that covered evidence collection and chain of custody. Finally, the Auditor reviewed one sexual abuse investigative file. The allegation involved an inappropriate proposal; and therefore, no physical evidence was present, and the facility does not have audio recording capabilities inside the housing unit.

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

(b) SLRDSC Policy 2.11 also states that, "The Warden shall consider how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victim's needs. The Facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. The facility shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified to victims of sexual assault of all ages. As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. A qualified agency staff member or a qualified

community-based staff member means as individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals."

The SLRDSC provides the National Sexual Assault Hotline poster with contact information to the detainees housed at the facility. The SLRDSC also provided information for the only Rape Crisis Center (Amberly's Place) in Yuma, Arizona. The Auditor contacted the Amberly's Place Rape Crisis Center and spoke to the Director. The Director informed the Auditor that they do not, nor will they provide any advocacy to incarcerated individuals, including detainees housed at the SLRDSC. When calling the National Sexual Assault Hotline, the Auditor was told that they would assist the individual in getting in contact with the local rape crisis center. In this situation, the only local rape crisis center is not willing to provide the services associated with sexual abuse advocacy at the SLRDSC. The facility also provided a memorandum written by the Warden indicating that a community-based staff member was willing to provide the services of an advocate for sexual abuse victims at the SLRDSC. However, the Auditor has determined that the community-based staff member has not received the necessary training as outlined in this provision to provide those services at this time. The AW informed the Auditor that the community-based staff member advised the AW that he did not currently possess the required training to provide rape crisis advocacy.

When interviewing the PSA Compliance Manager, he indicated that they do provide detainee victim advocacy through the National Rape Crisis Hotline and that they have a community-based volunteer that is willing to be a sexual abuse advocate for the facility.

Does Not Meet (b): SLRDSC Policy 2.11 states in part that "The Facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. A qualified agency staff member or a qualified community-based staff member means as individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals." The SLRDSC listed Amberly's Place through the National Rape Crisis Center as their rape crisis advocate. The Auditor contacted this advocacy center and spoke to the Director, who informed that the advocate will not provide crisis services to the SLRDSC. Therefore, the facility attempted to provide a community-based advocate to offer these services, but the community-based advocate has not received the appropriate training in accordance with provision (b) to qualify as a sexual abuse crisis advocate. The SLRDSC must provide victim services following incidents of sexual abuse. The facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If the rape crisis center is unable to provide these services, the agency shall provide these services by making available a qualified staff member from a community-based organization or a qualified agency staff member. Either of these individuals must receive education concerning sexual assault and forensic examination issues in general.

Recommendation (b): The Auditor recommends that all Amberly's Place Rape Crisis Center posters be removed from all the housing units within the facility given the agency cannot provide services to incarcerated detainees.

(c)(d) SLRDSC Policy 2.11 further states that, "The Facility shall offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside the facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The facility shall document its efforts to provide SAFEs or SANEs. The results of the physical examination and all collected physical evidence are provided to the investigative entity." SLRDSC Policy 2.11 further states in part that, "As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews."

The Auditor interviewed the Director of the Amberly's Place Rape Crisis Center which provides SANE nurses for the Yuma Regional Medical Center. These nurses are employed by the Rape Crisis Center and not the hospital. The Director informed the Auditor that her SANE nurses conduct FMEs for the community of Yuma, Arizona. When asked if they would conduct those examinations for detainees of the SLRDSC, she stated "yes they would." She also confirmed that those services are offered 24 hours a day, 365 days a year. Medical staff confirmed that the detainee's consent is required for the FME. The facility reported no incidents of sexual abuse that required an FME. The Auditor did not interview a detainee who reported sexual abuse because at the time of the on-site audit phase no detainees currently in custody had reported sexual abuse. The Auditor reviewed one investigative file that involved an inappropriate proposal between two female detainees. No FME was required regarding this case that occurred in 2019.

(e) SLRDSC Policy 2.11 states that, "To the extent that LSC is not responsible for investigating allegations of sexual abuse, LSC shall request that the investigating agency follow the uniform evidence protocol requirements." The SLRDSC provided a MOU between the SLRDSC and SLPD which contains the appropriate language requesting that the SLPD follow the requirements outlined in paragraphs (a) through (d) of this section.

§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a) LSRDSC Policy 2.11 states that, "LaSalle Corrections will ensure all allegations of sexual abuse and harassment are referred for

investigation to the applicable local law enforcement agency to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. Facilities shall document all referrals." The SLRDSC provided a copy of the MOU with the SLPD that outlines the response and responsibility of each agency as it regards to the investigation of suspected criminal activity involving sexual abuse.

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

The AW stated that when a sexual abuse allegation is made the facility activates its Incident Command System (ICS) which indicates who and when all notifications must be made. The supervisor on duty writes a Significant Incident Report (SIR) and a PREA investigation is initiated. If probable cause exists, the SLPD is notified to conduct a criminal investigation. A separate administrative investigation is completed by the facility and a final investigative file is completed with the findings. The investigation is reviewed by both the Warden and AW before being sent to the FOD. The Facility Investigator indicated that a PREA checklist/coordinated response plan is used if a sexual abuse allegation is made. He also stated that all administrative investigations are conducted by the specially trained facility Lieutenants and that the SLPD conducts any criminal investigations. The one sexual abuse allegation reviewed by the Auditor involved two female detainees. The allegation was that an inappropriate proposal was made that inferred possible sexual misconduct. The SLPD was contacted and determined no probable cause existed that a crime was committed given the nature of the allegation; therefore they declined to investigate.

(b)(d)(e)(f) SLRDSC Policy 2.11 also states, "Where sexual abuse is alleged, The Facility shall use investigators who are specially trained, qualified investigators in sexual abuse investigations and they must be prompt, thorough, objective, and fair. When possible and feasible, appropriate staff preserve the crime scene, and safeguard information and evidence in coordination with the referral agency and consistent with established evidence gathering and evidence processing procedures. SLRDSC shall ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for investigation by an agency with the legal authority to conduct criminal investigations and shall document such referrals. Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The agency shall maintain sexual abuse data collected for at least 5 years after the date of the initial collection unless Federal, State, or local law requires otherwise."

Policy 2.11 requires the Facility Administrator, PSA Compliance Manager, Facility Investigator, Corporate PREA Coordinator, and other designated individuals and the ICE AFOD or designee to be notified within two (2) hours of the occurrence. When a detainee(s) is alleged to be the perpetrator, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to the FOD, and/or designee, and the OPR JIC. All perpetrators of sexual abuse or assault shall be disciplined and referred for criminal prosecution as appropriate. When an employee, contractor or volunteer, inmate, prisoner, or detainee is alleged to be the perpetrator of detainee sexual abuse and/or assault, it is the facility administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to the FOD, and/or designee, who shall report it to the OPR JIC.

When the Facility Investigator was asked what external individuals or agencies the facility would report a sexual abuse allegation, he stated the JIC and the SLPD. The AW indicated during his interview that the JIC, OPR, FOD, local law enforcement, and the LaSalle corporate office would be notified.

The AW indicated that when a sexual abuse allegation is made the facility activates its ICS which indicates who and when all notifications must be made. Part of the ICS protocol is to make sure ICE is notified through email via Joint Intake Center (JIC) and the FOD. The PSA Compliance Manager stated that the facility would provide ICE with all the information needed regarding an alleged sexual abuse by a detainee. Finally, the investigative staff member reiterated the statements made by the PSA Compliance Manager. The Auditor reviewed one sexual abuse investigative file from 2019. This file indicated that ICE was notified regarding the allegation. In addition, information received from the Team Lead also indicates that ICE was notified about this case; however, no JICMS or SAAPI number was assigned.

Does Not Meet (f): The facility has not demonstrated that ICE JICMS was notified of the one allegation that occurred during the audit period. Although the Auditor's review of the investigative file indicated all notifications were made, the allegation spreadsheet provided by the ERAU Team Lead indicated no JICMS or SAAPICM number was issued which appears it was not reported to the

Agency. However, an email from the Team Lead indicates that ICE ERO was notified by the facility, but ERO did not report the incident to JIC or SAAPI. To become compliant, the facility must establish procedures to ensure that all allegations are promptly reported to the agency as described in paragraphs (e) and (f) of this standard. Additionally, any new allegations that occur during the CAP period must be promptly reported to the agency according to these procedures and evidence must be provided to the Auditor for compliance review.

(c) The Auditor confirmed that both the Lasalle (https://lasallecorrections.com/human-rights) and ICE (https://www.ICE.gov/prea) websites contain their respective protocols as it relates to PREA, and commitment to comply with those standards.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) SLRDSC Policy 2.11 states in part that, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all employees and shall also be included in annual refresher training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under this standard, and shall include: (a) The facility's zero-tolerance policies for all forms of sexual abuse; (b) definitions and examples of prohibited and illegal sexual behavior; (c) the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; and examples of prohibited and illegal sexual behavior; (d) instruction that sexual abuse and/or assault is never an acceptable consequence of detention; (e) recognition of situations where sexual abuse and/or assault may occur; (f) how to avoid inappropriate relationships with detainees; (g) working with vulnerable populations and addressing their potential vulnerability in the general population; (h) recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; (i) the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee victim's welfare, and for law enforcement/investigative purposes; (j) The investigation process and how to ensure that evidence is not destroyed; (k) Prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; (l) how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; (m) Instruction on reporting knowledge or suspicion of sexual abuse and/or assault; and (n) Instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault."

The policy further states, "The Facility shall maintain written documentation verifying employee, volunteer, and contractor training." The SLRDSC provided the PREA training curricula in a PowerPoint format for the Auditor's review which included all the required elements of training along with signature pages identifying those officers that received the initial PREA training during their initial correctional officer training curriculum. They also provided signature pages from their PREA annual refresher training. The Auditor reviewed 11 employee files during the document review phase and confirmed that all the files that were reviewed contained evidence of the initial PREA employee training and annual refresher training. The files reviewed also included three service contractors. Finally, the facility provided DHS PALMS training certificates of completion for those ICE Compliance Officers assigned to the facility. All this information was confirmed and provided by the Training Supervisor during the on-site audit phase and during the interview. During the interviews, 12 random staff members were asked if they had received PREA training and when it occurred. All 12 random staff members indicated that they had received the training during their initial training in the Academy. The random staff members also stated that they receive annual PREA training in the training classroom at the facility.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) SLRDSC Policy 2.11 states in part that, "The Facility shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies, and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the zero-tolerance policy and informed how to report such incidents. In this paragraph "other contractor" means a person who provides services on a non-recurring basis to the facility pursuant to a contractual agreement with the agency or facility. The Facility shall maintain written documentation verifying employee, volunteer, and contractor training."

The SLRDSC provided a PowerPoint presentation slide that contained information regarding their zero-tolerance policy and the ways to report sexual abuse along with how to detect, respond to and prevent sexual abuse. The Training Supervisor was asked during his interview if contractors and volunteers that have contact with detainees are provided with the agency's zero-tolerance policy and how to report sexual abuse. The Training Supervisor indicated that volunteers and contractors receive the same training as the facility staff. The facility also provided signed PREA training acknowledgement forms for religious volunteers. The Auditor interviewed a volunteer who confirmed that they had received the PREA training. Finally, the Auditor reviewed three service contractor files that contained evidence that the PREA training had been completed.

§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) SLRDSC Policy 2.11 states, "Detainees shall be informed about LaSalle Corrections Sexual abuse and assault prevention and intervention program and zero-tolerance policy for sexual abuse and assault through the orientation program and the detainee

handbook. Detainee notification, orientation, and instruction must be in a language or manner that the detainee understands. Prohibits all forms of sexual abuse or assault staff on detainee, detainee on detainees; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of contact line officer, (e.g., the compliance manager or a mental health specialist) the Detention and Reporting Information Line (DRIL), the DHS Office of Inspector General, and the Joint Intake Center; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; The right of a detainee who has been subjected to sexual abuse to receive treatment and counseling."

(c) The SLRDSC provided the Auditor with a Detainee Orientation/PREA Briefing Log. This document contained the date, time, and signatures of ICE detainees acknowledging the PREA educational video. The PSA Compliance Manager explained that the detainees are staged in the intake area when they arrive. They are shown the PREA orientation educational video and issued both the ICE and SLRDSC Handbook. The intake officers then have each detainee sign the briefing log acknowledging that the information was provided to them.

The policy further states that, "Detainee notification, orientation, and instruction must be in a language or manner that the detainee understands, including for those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. Shall maintain documentation of detainee participation in the instruction session. The Facility shall have a TTY machine available in the Intake Processing Area. The Facility shall ensure that detainees have multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents."

The SLRDSC provided several slides from their PREA orientation presented in video format both in English and Spanish. This video is shown on several television monitors in the Intake and Receiving area. This process was observed by the Auditor during the on-site facility tour and the Auditor confirmed the video contained the six topics outlined in provision (a) of this standard by reviewing the video. The detainees are staged in the intake area when they arrive. They are shown the orientation briefing videos and issued the ICE National Detainee Handbook and the SLRDSC Handbook. The intake officers then have each detainee sign for the orientation as it is completed. Because there is limited space in the intake area, large groups of detainees are separated into the various holding rooms and processed in smaller groups. The video is displayed in English and Spanish, and the Intake Officer has the detainee acknowledge watching the video by signing a Detainee Orientation/PREA Briefing Log. For those detainees that speak/understand languages other than English and Spanish, the SLRDSC provides the SLRDSC Handbook in the language needed by using a translation software at the facility. They also provide the ICE National Detainee Handbook that is available in fourteen different languages: English, Spanish, Arabic, Bengali, Chinese, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Turkish, and Vietnamese. The video has audio for those detainees that are visually impaired and contains closed captioning for those detainees that are hard of hearing or deaf. Policy 2.11 states, "Where practicable, provisions for written translation of materials related to sexual abuse or assaults shall be made for any significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." The Auditor reviewed the SLRDSC Handbook in English and observed the explanation of methods for reporting sexual abuse, prohibition against retaliation, and the right of a detainee that has been subjected to sexual abuse to receive treatment and counseling. In addition, prevention and intervention strategies, definitions or examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, coercive sexual activity, and self-protection and indicators of sexual abuse. All the necessary contact information regarding the DHS OIG and ICE DRIL was present in the SLRDSC Handbook and ICE National Detainee Handbook. The Intake Officer was interviewed and confirmed this practice. She also verified that if needed, a TTY for deaf detainees is available in the Intake area. The Auditor interviewed one detainee who also confirmed he watched the video and received an ICE National Detainee Handbook in Chinese and a SLRDSC Handbook in Mandarin. The SLRDSC provided copies of the detainee orientation/PREA briefing Log that contains the signatures of ICE detainees acknowledging watching the detainee educational video.

When conducting interviews with 12 random staff members they were asked if they had ever encountered a detainee that was blind, deaf, or intellectually disabled and they all stated "no." When asked how they would provide that information, the random staff interviewed indicated that deaf detainees could read the closed caption video, read the facility, and ICE National Detainee Handbook or they could arrange for a sign language interpreter. When discussing blind detainees, the staff indicated through the audio of the video, or they could read the information to them. Finally, regarding those detainees that were intellectually disabled, the random staff indicated they would contact the medical section for assistance and that it depended on the detainee's level of comprehension if they could read the information in a manner that the detainee could understand.

(d)(e) SLRDSC Policy 2.11 states that, "The Facility shall provide detainees with the name of the program coordinator or designated staff member and information on how to contact him or her. Detainees will also be informed that they can report any incident or situation regarding sexual abuse, assault, or intimidation to any staff member (as outlined above), the DHS Office of Inspector General, and the Joint Intake Center. The Facility shall provide instructions on how detainees may contact their consular official, the DHS Office of Inspector General, or as appropriate, another designated office, to confidentially and, if desired, anonymously report these incidents. The Facility shall inform the detainees of at least one way for detainees to report sexual abuse to a public or private entity or office that is not part of LaSalle Corrections."

The Auditor observed the DHS-prescribed SAA Information pamphlet, the DHS zero-tolerance posters with contact information for the

facility's PREA Compliance Manager and the consular contact informational flyer posted in all the housing dorms. The National Rape Crisis Hotline advocacy flyers were also posted in the housing dorms. Finally, the facility makes available the DHS-prescribed SAA Awareness Information pamphlet, in nine languages, for distribution to detainees, as needed. Those languages are English, Spanish, Arabic, Chinese, French, Haitian Creole, Hindi, Punjabi, and Portuguese.

(f) The SLRDSC issues all ICE detainees the ICE National Detainee Handbook. Located on page 33 of this handbook is all the information regarding how to report a sexual abuse allegation through the reporting mechanisms provided by ICE. The Auditor confirmed this practice through interviews with the Intake Staff and Classification Officer. When reviewing the detainee files, notations were observed confirming receipt of both handbooks and what language the handbooks were provided in.

§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) SLRDSC Policy 2.11 states that, "Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The Facility shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Any State entity or Department of Justice component that investigates sexual abuse in confinement settings shall provide such training to its agents and investigators who conduct such investigations." The SLRDSC provided copies of certificates of completion for four trained investigators. These certificates are through the National Institute of Corrections (NIC) and validates specialized training in the field of investigating sexual abuse in a confinement setting.

The Auditor reviewed the lesson plan, ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency provides the lesson plan and rosters of trained ICE/ERO/OPR investigators on OPR's SharePoint site for Auditor's review; this documentation is in accordance with the standard's requirements.

The Auditor reviewed one administrative investigation file from November of 2019. The Facility Investigator was assigned and conducted that investigation. The Auditor verified that the Facility Investigator has received the necessary specialized training. When interviewing the Facility Investigator, he indicated that he and the other investigators had previously received training regarding cross-agency coordination concerning sexual abuse allegations made by ICE detainees.

§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 SLRDSC provided a memo dated April 13, 2022, signed by the Warden stating there are no ICE Health Service Corps staff assigned to the facility; therefore, these provisions are not applicable.

(c) SLRDSC Policy 2.11 states that, "The Facility shall ensure that all full-and part-time medical and mental health care practitioners are provided with specialized training, to include: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment." The policy further states that, "The training department shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. Medical and mental health care practitioners shall also receive the training mandated for employees under 115.31 or for contractors and volunteers under 115.32, depending upon the practitioner's status at the agency." At the conclusion of SLRDSC Policy 2.11 is a review signature page that contains both the Facility Administrator's signature and the ICE Assistant Field Office Administrator's (AFOD) signature acknowledging the review of policy 2.11 dated June 1, 2022.

The SLRDSC uses contracted medical personnel and provided the curriculum for specialized training for medical and mental care standards through the NIC on-line educational platform. The Auditor interviewed both a mental health professional and medical staff member who indicated that they had received specialized training through the NIC website. The Training Supervisor indicated that the medical staff receive the specialized training through NIC and that he manages that task. The mental health professional is contracted once a week and when needed. When reviewing employee files, the Auditor reviewed two medical staff files. Both files had evidence that they had received the initial basic training in accordance with 115.31 and specialized training.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b) SLRDSC Policy 2.11 states in part that, "The Facility shall assess all detainees upon intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. The Facility shall also use the information to inform assignment of detainees to recreation and other activities, and voluntary work. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly." The policy further states that, "All detainees will be screened within 12 hours of their arrival at the facility for potential vulnerabilities or

tendencies of acting out sexually aggressive behaviors. Housing assignments are made accordingly. Detainees identified as being at risk for sexual victimization are monitored and counseled and are placed in the least restrictive housing that is available and appropriate."

The Intake Officer explained that the booking process is part of the classification process. The detainees are initially held in several large holding tanks and are brought out approximately ten at a time where they watch the PREA educational video. Once that is completed, the Intake Officer runs a background criminal history check through ICE which is called a 213. Then the PREA risk screening questions consisting of yes and no questions are asked. All the information collected at the initial booking process is used to determine housing. The security classification criteria are either minimum, medium, or maximum custody levels. All detainees are housed accordingly with other like detainees. Once the booking classification process is complete, the detainee is immediately taken to the nurse's station to be medically screened. The Intake Officer stated that if a detainee answers yes to two or more risk screening questions related to possible victimization, the Intake Officer would immediately notify the nurse assistant who will conduct the medical screening. The Intake Officer indicated the initial classification and housing assignment is completed within the first two hours and would never exceed twelve hours. During the file review process, the Auditor reviewed 11 detainee files and confirmed that the detainees were booked and processed to include housing assignments and risk screening within the first two hours. The classification sergeant was interviewed and reiterated the comments and practice outlined by the Intake Officer.

(c)(d) SLRDSC Policy 2.11 also states, "The following criteria will be used in screening to assess detainees for risk of sexual victimization and sexual abusive behavior: Whether the detainee has a mental, physical, or developmental disability; The age of the detainee; The physical build and appearance of the detainee; Whether the detainee has previously been incarcerated or detained; The nature of the detainee's criminal history; Whether the detainee has any convictions for sex offenses against an adult or child; Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; Whether the detainee has self-identified as having previously experienced sexual victimization; The detainee's own concerns about his or her physical safety." The policy further states that, "The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in addressing detainees for risk of being sexually abusive." The Auditor had the Intake Officer walk through the booking/classification process. The Auditor viewed the risk screening form on the computer and the above listed questions were present. The Auditor also observed eight prior completed risk screening forms from previous ICE detainees. The Intake Officer stated that information collected during the PREA risk screening ensures that possible sexual abuse victims would not be housed or intermingled with possible abusers.

(f) SLRDSC Policy 2.11 further states that, "detainees shall not be disciplined for refusing to answer or not disclosing complete information in response to questions (1), (7), (8), and (9). Both the PSA Compliance Manager and Intake Officers indicated that no detainee would be disciplined for not answering any questions associated with the risk screening form.

(e) SLRDSC Policy 2.11 states that, "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. Detainees shall not be disciplined for refusing to answer or not disclosing complete information in response to questions (1),(7),(8),(9)." The PSA Compliance Manager and Intake Officer indicated that they usually receive between 70 and 150 ICE detainees any given week either on a Monday or Tuesday. The entire population is generally transferred out the following Sunday, excluding any detainee that tests positive for COVID-19. Therefore, they never hold ICE detainees for any significant length of time that would surpass the 60–90-day reassessment. Both the PSA Compliance Manager and Intake Officer stated that if a detainee was still in their custody after the conclusion of an investigation, then a reassessment would be conducted. The investigative file of the one incident that occurred during the audit period indicated the victim was reassessed after the incident was reported. The allegation was unsubstantiated, and the alleged perpetrator was released the day after the investigation closed.

(g) SLRDSC Policy 2.11 also states that, "The Facility shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this screening in order to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees." When interviewing the PSA Compliance Manager and Intake Officer, they indicated that only staff assigned to classification, facility administrators, and medical personnel have access to the risk screening assessment forms.

§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) SLRDSC Policy 2.11 states in part that, "Screening Information from the risk screening required to inform housing, bed, work assignments within the Facility in order to keep potential victims away from potential abusers. Detainees identified as being a risk for sexual victimized are monitored and counseled and placed in least restrictive housing that is available and appropriate." The PSA Compliance Manager stated when interviewed that the facility uses a classification tool that identifies those detainees that should be categorized as minimum, medium, or maximum custody level. He also stated that the PREA risk screening helps in identifying those detainees that may be vulnerable to sexual victimization and those detainees that may be sexual predators. When these individuals are identified, the facility can ensure they are not housed together or socialize in any programs or recreation. The facility reported no instances where a detainee was identified as a possible victim or potential predator.

(b) SLRDSC Policy 2.11 states that, "In making assessment and housing assignments, for Transgender and Intersex detainees shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. Medical and mental health professionals shall be notified as soon as practicable on this assessment. The Facility shall not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. The LaSalle Corrections placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender of intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee." The SLRDSC provided a memo dated April 15, 2022, signed by the Warden indicating that they have not received any transgender/intersex ICE detainees during the audit period. The HSA was interviewed and stated that intake staff would consult with medical personnel when determining appropriate housing for a transgender detainee. The mental health professional indicated that he may or may not meet with a transgender detainee but would be consulted regarding housing assignments. The Intake Officer indicated that the procedure is to ask the detainee who they want to be searched by and if they have any concerns with any housing arrangements. The Classification Officer confirmed that transgender detainees must be reassessed twice a year; however, he has never had a known transgender/intersex detainee at the facility. Based on interviews with the HSA, DW, and PSA Compliance Manager, there have been no identified transgender or intersex detainees at the facility within the audit period.

(c) SLRDSC Policy 2.11 states that, "Transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." When interviewing the PSA Compliance Manager, he was asked if transgender or intersex detainees could shower separately from other detainees. The PSA Compliance Manager stated they would be allowed to shower in a single private shower room in the intake area. When the Intake Officer was asked the same question, she indicated that if the transgender/intersex detainee made that request, the facility would accommodate the request. Finally, 12 random staff members were asked this question and all 12 answered that the transgender or intersex detainee would be able to shower separately in the single occupancy shower room located in the Intake Center.

§115.43 - Protective custody.

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

Notes:

(a) SLRDSC Policy 2.11 states, "The victim shall be housed in a supportive environment that represents the least restrictive housing option possible, and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. Detainee victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee." The AW was interviewed and stated that if a detainee needed to be placed in protective custody/administrative segregation, the facility would immediately notify the ICE FOD and have the detainee moved to another facility. Also, the SLRDSC Policy 2.11 was approved and acknowledged by the AFOD dated June 1, 2022.

(b) SLRDSC Policy 2.11 states that, "Detainees at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If the facility cannot conduct such an assessment immediately, the facility may hold the detainee in involuntary segregated housing for less than 24 hours while completing the assessment. The facility shall assign such detainees to involuntary segregated housing only 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 AW stated that detainees would be held in administrative segregation for the least amount of time as practicable and no longer than 30 days. He stated that he has never experienced a situation where a detainee was placed in protective custody. However, if that were to happen, he would immediately contact ICE and have the detainee transferred to another facility. The AW stated that until those arrangements could be made, he would have a mental health professional meet with the detainee on a regular basis.

(c) SLRDSC Policy 2.11 states, "Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If the facility restricts access to programs, privileges, education, or work opportunities, the facility shall document the opportunities that have been limited; the duration of the limitation; and the reasons for such limitations." The 12 random staff members indicated that if a detainee were placed in protective custody that detainee would be afforded the same opportunities and privileges as all other detainees. The SLRDSC provided a memo dated April 9, 2022, signed by the Warden indicating that there have been no instances where an ICE detainee was placed in protective custody/administrative housing during this audit period, which was also confirmed during interviews with staff who work the segregation unit.

(d) SLRDSC Policy 2.9.1 states that, "A supervisor will conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. The review shall include an interview with the detainee and a written record shall be made of the decision and the justification. If the detainee has been segregated for his or her own protection, but not at the detainee's request, the signature of the facility administrator or assistant facility administrator is required to authorize the detainee's continued placement in administrative segregation." During the interview with the AW, he explained that his Classification Sergeant (Sgt.) would conduct a review within 72 hours and if the detainee were being held in protective custody involuntarily then he would have to sign off on the authorization to continue the segregation. However, the AW stated that he would have the detainee transferred immediately to a different ICE facility. The policy further states that, "A supervisor will conduct an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter, at a minimum."

(e) SLRDSC Policy 2.11 states that, "The Facility shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours." The AW indicated that contact would immediately be made with the AFOD or FOD notifying them of the initial placement of a detainee in administrative segregation/protective custody.

Recommendation (e): The Auditor recommends adding language to Policy 2.11 regarding 115.43(e) that states, whenever a detainee has been placed in administrative segregation "on the basis of a vulnerability or sexual abuse or assault."

§115.51 - Detainee reporting.

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

Notes:

(a) SLRDSC Policy 2.11 states that, "The Facility shall ensure that detainees have multiple ways for detainees to privately report sexual abuse and sexual harassment, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. LSC shall provide instructions on how detainees may contact their consular official, the DHS Office of the Inspector General or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents." The facility provided examples of both the DHS OIG Hotline poster and the DHS ICE Consular list poster. Both posters contain the necessary contact information. The Consular list poster contains 171 different Embassy or Consulate phone numbers and an additional 20 numbers for outside resources in the United States. These posters were observed in the housing dorms during the on-site facility tour and the DHS OIG contact information can be found in both the ICE National Detainee Handbook and the SLRDSC Handbook. These informational posters contained contact numbers for both the ICE DRIL and DHS OIG. The poster also stated that the detainee may remain anonymous when making a report if they chose. The PSA Compliance Manager was asked how detainees can report sexual abuse. He indicated they can report sexual abuse to any staff member, contractor, volunteer, outside family members, Attorney, OIG hotline, ICE DRIL, advocate, and their consular office. When interviewing the only ICE detainee in custody, he was asked aside from when he first arrived, did he recall seeing or hearing about information in the ways he could report a sexual abuse? The detainee stated that yes, he seen the posters in his room.

(b) The SLRDSC Policy 2.11 also states that, "The Facility has one way for detainees to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward detainee reports of sexual abuse and sexual harassment to agency officials, allowing the detainees to remain anonymous upon request. Detainees shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security." The SLRDSC utilizes the OIG hotline as their outside reporting entity for ICE detainees being held in their facility. While conducting the tour, the Auditor attempted to contact the DHS OIG through a phone located in a housing unit. The Auditor was able to make contact with a representative and explained the purpose of the call and requested they make the necessary notifications so that the Auditor could confirm the effectiveness of this outside reporting entity. The DHS OIG representative confirmed a call to the DHS OIG hotline is both confidential and anonymous if requested. On the last day of the audit, the Auditor emailed the two ERO agents that were present during the facility tour and asked if they had been notified by DHS OIG or ICE and they both responded that they had not. The Auditor again sent an email to both ERO agents on July 13, 2022, again asking if they had received any confirmation from the DHS OIG or ICE. The Auditor received a reply that they had not received any notifications of my test call.

(c) SLRDSC Policy 2.11 further states, "Employees shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports." Random staff were asked if they would accept sexual abuse reports verbally, in writing, anonymously, and by a third party. All 12 random staff members answered yes, they would accept sexual abuse reports in all those manners and promptly document the report. When reviewing the one sexual abuse allegation, the detainee verbally reported the incident to the security staff member. While interviewing the one detainee who was present during the audit, he was asked if he knew if he could report a sexual abuse without providing his name. The detainee indicated that yes, he was aware. Finally, The PSA Compliance Manger stated that detainees can privately report sexual abuse by calling the DHS OIG or writing to the ERO agent and dropping the request form in the ICE secure mailbox located in all the housing dorms.

§115.52 - Grievances.

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

Notes:

(a)(c) SLRDSC Handbook states that, "an emergency grievance involves an immediate threat to a detainee's health, safety, or welfare. When a staff member determines that a detainee is raising an issue requiring urgent attention, the facility's emergency grievance procedures apply. A detainee may give emergency grievances to the Grievance Officer or directly to the Shift Supervisor. If the Shift Supervisor determines that the grievance is an emergency matter it will be given immediate attention. Emergency grievances that cannot be resolved at the shift level will be channeled immediately through the chain of command until a level is reached where action can be taken. If, upon consideration, the matter is not in fact an emergency issue, then standard processing will apply. Regarding regular grievances you will receive a written response within 30 days of filing the original grievance. All Grievances will remain in the detainee's file for at least three years." SLRDSC Policy 2.11 states that, "the Facility staff shall be responsible on identifying and handle time-sensitive grievances that involve an immediate threat to detainees, health, safety, or welfare related to sexual abuse." The Grievance Coordinator stated during her interview that she would accept a sexual abuse allegation made through the grievance process. She was also asked if there is a different set of procedures for responding to time sensitive grievances regarding sexual abuse. The Grievance Coordinator explained that when she receives an emergency grievance, she takes immediate action. She is required to contact the PSA Compliance Manager who will assign a facility investigator to investigate the allegation. In addition, 12

random staff members were asked the same question and they answered they would accept a sexual abuse report through the grievance process. However, it was explained that if the detainee placed the grievance in the grievance box, then no security staff has access to the box, excluding the Grievance Coordinator and Command Staff. The SLRDSC provided a memo dated April 15, 2022, signed by the Warden that the facility has not received any grievances related to sexual abuse from ICE detainees during the audit period.

(b) SLRDSC Policy 2.11 states that, "no time limits will be set when a detainee may submit a grievance regarding an allegation of sexual abuse or sexual assault." The Grievance Coordinator indicated that there are no time limits on when a detainee can submit a grievance regarding an allegation of sexual abuse. The SLRDSC Handbook states, "SLRDSC does not impose a time limitation for detainees to file a sexual abuse and assault grievance."

(d) SLRDSC Policy 2.11 states, "the Facility shall be responsible to alert proper medical personnel of any sexual abuse-related medical emergencies." The Grievance Coordinator and random staff were asked if they received a grievance related to sexual abuse, would they notify medical staff. Both the Grievance Coordinator and all the random staff interviewed indicated that yes, they would notify medical personnel immediately.

(e) The SLRDSC Handbook states that, "if a detainee files a grievance related to a sexual abuse claim, SLRDSC shall issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. A report of all such grievances is sent directly to the ICE/ERO FOD)." The Grievance Coordinator confirmed that a response would be provided in five days and an appeal regarding the decision within 30 days.

(f) SLRDSC Policy 2.11 states, "third parties (e.g., fellow detainees, Employees, family members, attorneys, and outside advocates) may assist individual's detainees in filing requests for administrative remedies relating to allegations of Sexual Abuse and Sexual Harassment and may be file such requests on behalf of the alleged victim." When conducting interviews with random staff and the Grievance Coordinator they were asked how they would expedite a detainee's request for assistance from another person, to help file a grievance. The Grievance Coordinator stated she would provide immediate assistance and majority of the random staff members interviewed indicated they would facilitate communication between the detainee and the third-party that is trying to assist, the others were unsure.

§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) SLRDSC Policy 2.11 states that, "the Facility shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to address victim's needs most appropriately. The facility shall make available, to the full extent possible, outside victim services following incidents of sexual abuse. The Facility shall also attempt to make available such victim services for any individuals identified as having experienced sexual victimization prior to entering DHS custody. The facility shall provide postings in all housing units with the community resources mailing address and telephone numbers (including toll-free hotline numbers where available)."

SLRDSC policy also states, "LSC shall maintain or attempt to enter into memoranda of understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime." The facility has attempted to enter an agreement with the only local Rape Crisis Center but the Center refuses. The SLRDSC has provided the National Sexual Assault Hotline poster with contact information to the detainees housed at the facility. When interviewing the PSA Compliance Manager, he indicated that they do draw on community resources such as the National Rape Crisis Hotline, their religious volunteer, and the local police department.

(c)(d) The SLRDSC provided the National Sexual Assault Hotline poster with contact information (i.e., phone number and mailing address) to the detainees housed at the facility. These posters indicate that the call is anonymous and will not be monitored or recorded. This same information is also provided in the SLRDSC handbook, which as previously stated, is translated in whatever language needed for the detainee using online software to ensure they have access to this information. As outlined and discussed in 115.21 of this report, there are no local advocates willing to assist the SLRDSC in this matter. The Auditor has confirmed this fact during a phone interview with the Director of the local organization. Policy 2.11 also states that, "the Facility shall enable reasonable communication between detainees and these organizations and agencies, in a confidential manner as possible. The Facility will inform detainees, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." When interviewed, the PSA Compliance Manager stated that they make detainees aware of these services by posting the information in the housing dorms and listing the information in the SLRDSC Handbook. The Auditor has confirmed this by observation.

§115.54 - Third-party reporting.

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

Notes:

SLRDSC Policy 2.11 states that, "LaSalle Corrections shall post publicly, third party reporting procedures on its public website to show its method receiving third-party reports of Sexual Abuse and Sexual Harassment." The Auditor's review of the ICE website, https://www.ice.gov/prea, and LaSalle website, https://lasallecorrections.com/human-rights, confirmed the websites have third-party reporting information available to the public on behalf of detainees. Policy 2.11 states, "All staff must immediately report any known

or suspected incidents or allegations of sexual abuse or assault through the facility's chain of command. If an employee chooses to contact outside the chain of command, [they] can contact facility Human Resource Department, and the National Sexual Assault Hotline at 1-800-656-4673. All PREA related incidents must be immediately reported. The facility administrator shall promptly report the incident to the ICE Field Office Director and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the facility administrator shall ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reporting to the Field Office Director." The SLRDSC has provided the ICE website where under the ICE ERO DRIL and the DHS OIG information is made available to the public to report many things including incidents of sexual or physical assault or abuse.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c)(d) SLRDSC Policy 2.11 states that, "the Facility shall require all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. SLRDSC shall ensure that all staff are trained on: appropriate reporting procedures, including a method by which staff can report outside the chain of command; Staff members who become aware of alleged sexual abuse shall immediately follow reporting requirements set forth in LSC's written policy and procedures; and apart from such reporting, staff shall not reveal 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." The one alleged sexual abuse investigation from 2019 indicated that the security staff member was notified, and that staff member informed her supervisor. The SLPD was contacted and determined no probable cause existed that a crime was committed given the nature of the allegation; therefore they declined to investigate. However, the facility conducted an administrative investigation.

The PSA Compliance Manager was interviewed and indicated that staff are aware that they are to report immediately any knowledge, suspicion, or information regarding sexual abuse, retaliation, or staff neglect. He also stated that staff can report incidents of sexual abuse outside their chain of command by going to the Human Resources staff. Finally, the PSA Compliance Manager indicated that the facility does not house juvenile detainees or vulnerable adult detainees. During the interview with the AW, he stated that the facility would immediately report any sexual abuse allegation to the local law enforcement agency and the JIC. When interviewing random staff, they were asked how and when they would report a sexual abuse allegation. All 12 staff members interviewed stated that they would report immediately to their supervisor and would limit the information to those with a need-to-know. Staff members also stated they would report to medical staff and several staff members also indicated they could report sexual abuse to ICE ERO officers. The SLRDSC policy 2.11 has been acknowledged and approved by an AFOD dated June 01, 2022.

§115.62 - Protection duties.

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

Notes:

SLRDSC Policy 2.11 states that, "when the Facility learns that a detainee is subject to substantial risk of imminent Sexual Abuse, it shall take immediate action to protect the alleged victim. Employees shall report and respond to all allegations of Sexually Abusive Behavior and Sexual Harassment. Employees should assume that all reports of sexual victimization, regardless of the source of the reports (i.e., third party) are credible and respond accordingly."

The Auditor asked 12 random staff during their interviews what action they would take if they had reasonable belief that a detainee is subject to substantial risk of imminent sexual abuse and all staff members interviewed indicated that they would immediately remove the detainee from the situation and contact a supervisor. The first line supervisor stated that he would interview the detainee to determine the circumstances and make necessary housing assignments or contact ICE ERO to decide if the detainee or alleged aggressor would need to be transferred to a different facility. Both the random staff and the first line supervisor confirmed that there have been no instances of a detainee who has been at substantial risk of imminent sexual abuse during the audit period.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d) SLRDSC Policy 2.11 states that, "Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. The agency shall document that it has provided such notification. The facility head or agency office that receives such notification, shall [e]nsure that the allegation is referred for investigation in accordance with these standards and reported to the appropriate ICE Field of Office Director."

The facility provided a memo dated April 18, 2022, signed by the Warden that indicated that there have been no instances where the SLRDSC received a sexual abuse allegation where the incident occurred at another facility or received an allegation from another facility alleging sexual abuse at the SLRDSC during this audit period. However, when interviewing the PSA Compliance Manager, he indicated that if the facility received an allegation regarding sexual abuse that occurred at another facility, the SLRDSC would

immediately notify that facility's administrator at least within 72 hours. He further stated that if his facility received a sexual abuse allegation from another facility that alleged to occur at SLRDSC, they would immediately initiate a PREA investigation into the matter. The AW confirmed that if the facility were made aware of a sexual abuse allegation that occurred at another facility, that confinement facility would be notified by his facility within 72 hours. He also confirmed that if an allegation is received from another facility, then a PREA investigation would be initiated. He further stated that ICE would be notified via email along with completion of a Critical Incident Report (CIR) that would be attached to the email.

§115.64 - Responder duties.

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

Notes:

(a)(b) SLRDSC Policy 2.11 states, "upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report shall be required to: separate any detainee who alleges that he/she has been sexually assaulted from the alleged assailant. Immediately notify the Facility Administrator or on call supervisor and remain on the scene until relieved by responding personnel. In the event this occurred, the ICE AFOD or designee will be notified. Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse or sexual abuse occurred within a time period that still allows for the collection of physical evidence, do not let the alleged abuser, and request that the victim does not take any actions that could destroy physical evidence, including as appropriate, washing, brush teeth, changing clothes, urinating, defecating, smoking, drinking, and eating. If the first responder is not security staff, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff."

The 12 random staff were interviewed and asked during their interviews what they would do if they learned that a detainee had been sexually abused and all security staff indicated that they would immediately separate the individuals involved, secure the scene, preserve the evidence, and request that the victim not brush their teeth, use the bathroom, change their clothes, shower, and notify the medical staff. All random staff also indicated that they would ensure the alleged perpetrator would not destroy physical evidence by placing the individual in a dry cell until the situation could be assessed. When interviewing both a volunteer and a contractor, they were asked what steps they would take to preserve evidence and report an incident of sexual abuse when they learned about it? Both individuals indicated that they would ensure the safety of the alleged victim immediately, notify security staff, and request that the alleged victim not use the restroom, eat, drink, change clothes, or take a shower. The contractor showed the Auditor a pocket card that was titled "First Responder to PREA Procedures" that has their responsibilities listed on it in case they ever encounter this situation. The one alleged sexual abuse investigation from 2019 indicated that the security staff member was notified, and that staff member informed her supervisor promptly and according to policy; however, the allegation involved an inappropriate proposal and therefore no physical evidence was needed to be protected.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) SLRDSC Policy 2.11 states that, "the Facility has developed a plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The plans shall coordinate actions of staff responders, which are Medical and Mental Health Practitioners, facility investigators, PREA Coordinator, Duty Warden and any other staff deemed necessary by the Facility Administrator. The Facility PREA Compliance Manager shall be [a] required participant and the Corporate PREA Coordinator shall be consulted as part of this coordinated response."

The facility provided a Coordinated Response Plan in the form of a check list that is called "PREA Procedures." This plan is broken down into "tactical priorities" and lists the responsibilities of the first responder, shift supervisor, incident commander, medical and mental health professionals, investigators, and the Warden. This emergency response plan is part of a larger response system called the ICS, that is utilized when the facility encounters emergency situations. The plan provides specific duties that must be conducted and contacts that must be made. It also provides a checklist that must be dated and initialed.

The AW was asked how the facility communicates and coordinates with affected staff following a response to a sexual abuse and he stated that response to any emergency situations is part of the emergency plan that is activated by the ICS and delegates out individual responsibilities to all those individuals involved in the critical incident.

(c)(d) The SLRDSC policy does not directly outline or address specific procedures when a victim of sexual abuse is either transferred between facilities covered by 6 CFR part 115, subpart A or B, or to other facilities not covered by 6 CFR part 115, subpart A or B. There are no written procedures that govern if the SLRDSC can inform the receiving facility of the incident and the victims potential need for medical or social services. The AW was interviewed and asked what information would be provided to the receiving facility if SLRDSC transferred an alleged victim. The AW stated that the only information provided to the receiving facility would be by way of a medical transfer summary and that only the details of the alleged sexual abuse would be provided to ICE officials.

Does Not Meet (c)(d): The information conveyed by the AW and review of the documentation provided did not support any procedures in place for complying with these subparts. To become compliant with (c), the facility must have procedures in place to inform the receiving facility of a sexual abuse incident and the victim's potential need for medical or social services when a detainee victim is transferred between DHS immigration detention facilities. To become compliant with (d), the facility must have procedures in place to inform the receiving facility of a sexual abuse incident and the victim's potential need for medical or social services when a

detainee is transferred to a facility not covered by paragraph (c) of this standard, unless the victim requests otherwise. These notifications must be documented and made available for compliance review.

§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:

SLRDSC Policy 2.11 states "in the case where staff, contractors, and volunteers are suspected of perpetrating sexual abuse, they shall be removed from all duties requiring detainee contact pending the outcome of an investigation. The Facility shall not enter into or renew any collective bargaining agreement or other agreement that limits a Facility's ability to remove alleged Employee sexual abusers from contact with any detainee pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted." During the interview with the AW, he indicated that if staff were involved in a sexual abuse allegation the staff member could be placed on administrative leave until the conclusion of the investigation. He also stated that if the contractor or volunteer were involved in a sexual abuse allegation, they would not be allowed back into the facility until the investigation was completed and a conclusion was determined. The AW reported that there were no staff, contractor, or volunteer on detainee allegations during this audit period.

§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) SLRDSC Policy 2.11 states that, "the Facility shall protect detainees and staff against retaliation for reporting sexual abuse, or for cooperating with an investigation into an allegation of sexual abuse."

The facility had one sexual abuse allegation (detainee-on-detainee) in November 2019, which the facility made available, and the Auditor reviewed. It was confirmed through the PSA Compliance Manager, AW, and the Team Lead there has not been any additional sexual abuse reports during the audit period.

(b)(c) SLRDSC also states that, "the Facility shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. SLRDSC policy further states "for at least 90 days following a report of sexual abuse, shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff, and shall act promptly to remedy any such retaliation. The PSA Compliance Manager shall monitor any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. DHS shall continue to monitor beyond 90 days for retaliation whenever a continuing need." The one reported sexual abuse allegation file was reviewed and indicated that retaliation monitoring was initiated.

The PSA Compliance Manager was interviewed and stated that if he were made aware of any possible retaliation regarding a sexual abuse allegation, he would immediately act on that information. The PSA Compliance Manager also stated that he monitors incident reports, housing changes, and meets with the alleged victim at the 30,60, and 90-day mark to ascertain how the alleged victim is doing. If monitoring staff, the PSA Compliance Manager explained he would monitor for negative performance reviews and adverse job assignment changes, or unscheduled leave or tardiness. The PSA Compliance Manager indicated that normally monitoring would be done for 90 days unless there is a need to extend that time-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) SLRDSC Policy 2.11 states, "the victim shall be housed in a supportive environment that represents the least restrictive housing option possible, and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault." SLRDSC Policy 2.11 also states that, "detainee victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee."

The SLRDSC advised they had not received any complaints of sexual abuse from ICE detainees that resulted in detainees being placed in protective custody, or restrictive housing to protect them from alleged sexual abuse. The PSA Compliance Manager indicated that if an alleged detainee victim needed to be placed in protective custody they would evaluate each incident on a case-by-case basis and if needed, the detainee would be housed in medical or a protective housing unit. During the facility tour, the Auditor noted that there were no ICE detainees being housed in a segregated housing area within the SLRDSC. The PSA Compliance Manager was asked how long a detainee victim would be held in any type of segregation and he stated no more than five days. The one alleged sexual abuse allegation involved the alleged perpetrator being transferred to another housing location.

(c)(d) Policy 2.11 further states that, "a detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. The Facility shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours." The AW was interviewed and stated that upon placing a detainee in protective custody, ICE is immediately notified. He also stated that ICE DOs come to the facility three times a week to check on the detainees. The PSA Compliance Manager stated that ICE would be notified within 72 hours of placing a detainee in

protective custody. Both the PSA Compliance Manager and AW confirmed that a reassessment of a detainee would be conducted before the detainee is returned to general population.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a) SLRDSC Policy 2.11 states that, "where sexual abuse is alleged, the Facility shall use investigators who are specially trained, qualified investigators in sexual abuse investigations and they must be prompt, thorough, objective, and fair." When interviewing the investigative staff member, he stated that he ensures that all investigations are prompt, thorough and objective by initiating an investigation right away and by using the policy checklist (coordinated response plan) to collect all the necessary information. The PSA Compliance Manager indicated that the Warden meets with his management team every morning and they would review the progress of the case. In addition, every Lieutenant has been trained to investigate sexual abuse allegations in a confinement setting. The Auditor reviewed one alleged sexual abuse case. The investigation was conducted by the Facility Investigator who has been specially trained in conducting sexual abuse allegations in a confinement setting. The SLPD was contacted and determined no probable cause existed that a crime was committed given the nature of the allegation, and they declined to investigate. The facility conducted an administrative investigation. Interviews with the alleged victim, perpetrator, and witnesses were conducted. The investigator used the preponderance of the evidence to determine the case finding and the incident was received on November 19, 2019 and concluded on November 26, 2019.

(b) SLRDSC also states, "upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity." The Facility Investigator interviewed stated that facility investigators would coordinate with other entities when conducting administrative sexual abuse investigations, which would include coordinating with ICE officials. The PSA Compliance Manager was asked the same question and replied they would coordinate with ICE, and if there was any indication of potential criminal activity, they could immediately contact the SLPD. The AW was interviewed and indicated that if a criminal investigation were unsubstantiated the facility would conduct an administrative investigation. Finally, when asked if a criminal investigation were substantiated or unsubstantiated, would the facility conduct an administrative investigation, the PSA Compliance Manager and Facility Investigator both stated yes, they would.

(c) Policy 2.11 states that, "administrative investigations shall; preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years."

Both the Facility Investigator and PSA Compliance Manager were asked what information/evidence the facility investigators would collect in a sexual abuse investigation. They indicated that their primary responsibility is to secure the scene and preserve the evidence until the SLPD can respond to collect physical evidence. However, the PSA Compliance Manager also stated that they would collect witness statements, video evidence, and logbooks. He also stated that all sexual abuse investigations are kept at the facility in the Lieutenant's Office, who is a facility investigator. The facility investigator indicated that he would complete and document the investigation after it was finished. Finally, the AW stated that the facility investigators would attempt to determine whether any failures at the facility led to the abuse. The Auditor reviewed one alleged sexual abuse case. The investigation was conducted by the Facility Investigator who has been specially trained in conducting sexual abuse allegations in a confinement setting. The investigation revealed that the SLPD was contacted, and they established there was no probable cause that a crime had been committed; therefore, an administrative investigation was conducted by the facility. The administrative investigation file contained interviews with the alleged victim, perpetrator, and witnesses. The investigation used the preponderance of the evidence to determine the case finding and the alleged victim was notified of the investigation results.

(e) SLRDSC Policy 2.11 further states that, "the departure of the alleged abuser or victim from the employment or control of The Facility shall not provide a basis for terminating an investigation." Both the Facility Investigator and AW confirmed this practice and procedure.

(f) Policy 2.11 states, "when outside agencies investigate sexual abuse, shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." The AW, PSA Compliance Manager, and Facility Investigator were all asked if the facility would cooperate with outside investigators, and all three staff members answered yes. The Facility Investigator stated that he would provide all information they required and would try to remain informed during the course of the investigation. He also stated that he would ensure the internal investigation did not interfere with the criminal investigation. The investigative file contained evidence that the ICE ERO and SLPD was notified about this allegation. The SLPD determined no probable cause existed that a crime was committed given the nature of the allegation, and they declined to investigate.

§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:

SLRDSC Policy 2.11 states that "the SLRDSC shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated." During the interview with the Facility Investigator, he indicated that the standard of proof in sexual abuse administrative investigations is the preponderance of the evidence. The Auditor reviewed the one investigative case file that occurred during the audit period and the findings of that case was based on the preponderance of the evidence.

§115.73 - Reporting to detainees.

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

Notes:

SLRDSC Policy 2.11 states that, "following an investigation into a detainee's allegation that he or she suffered sexual abuse in the facility, The Facility shall inform the detainees as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the detainee." The AW was interviewed and stated the Facility Investigator is the designate for notifying detainees who reported sexual abuse about the results of the investigation and any actions taken by the facility. The detainee is provided an investigation form letter informing them of the findings of the investigation which both the investigator and detainee sign acknowledging receipt of the notification. The Auditor reviewed one sexual abuse allegation investigation which revealed that the alleged victim was notified of the investigation results.

§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:

SLRDSC Policy 2.11 states that, "the Warden shall ensure that staff be subject to disciplinary or adverse actions, up to and including removal from their position and from the Federal service, when there is a substantiated allegation of sexual abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Termination shall be the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse." Policy 2.11 further states that, "all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies."

The SLRDSC provided a memo dated April 18, 2022, signed by the Warden stating, "the San Luis Regional Detention and Support Center (SLRDSC) has not received any complaints of sexual abuse from ICE detainees during the year preceding the audit. As a result, SLRDSC has not terminated, or otherwise sanctioned, any employee for violating sexual abuse polices during that time. In the event that a licensed security staff member is arrested for a violation, the Training Manager will notify The Arizona Department of Public Safety Licensing unit of the arrest." During the interview with the AW, he explained that staff that violate the sexual abuse policy is subject to disciplinary action up to and including termination. He also stated that if staff is terminated or resigns in lieu of removal for violating the sexual abuse policy, the SLPD is immediately contacted. Finally, the AW explained that if security staff resigns or is terminated due to violating the facility's sexual abuse policy, the Training Manager notifies the Arizona Department of Public Safety as the licensing body that controls the states corrections officer certifications. The SLRDSC PREA Policy has been acknowledged, signed, and approved on June 1, 2022, by an Assistant Field Office Director. The one case during the audit period did not involve a staff member.

§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:

SLRDSC Policy 2.11 states that, "any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Contractors and volunteers suspected of perpetrating sexual abuse shall be immediately 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 and volunteers who have not engaged in sexual abuse but have violated other provisions within these standards." The SLRDSC provided a memo dated June 18, 2022, and signed by the Warden which states, "the San Luis Regional Detention and Support Center (SLRDSC) has not received any complaints of sexual abuse from ICE detainees during the year preceding the audit. As a result, SLRDSC has not terminated, or otherwise sanctioned, any contractors or volunteers for violating sexual abuse polices during that time. The AW was interviewed and explained that the facility's policy on addressing sexual abuse allegations involving contractors or volunteers was zero-tolerance and would prohibit access to any contractor or volunteer until the investigation was complete. He also stated that local law enforcement would be notified as well as the contracting agency. The AW stated that it would be the responsibility of the contracting agency to notify whichever licensing body that may be involved in oversight of that profession. The one case during the audit period did not involve a contractor or volunteer.

§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) SLRDSC Policy 2.11 states that, "detainees shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the detainee engaged in detainee-on-detainee sexual abuse or following a criminal finding of guilt for detainee-on-detainee sexual abuse. 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." When interviewing the AW, he stated that the facility disciplines detainees who have engaged in sexual abuse. He further stated that the detainee would have a due process hearing and if found guilty would receive disciplinary sanctions." The Auditor reviewed one allegation of sexual abuse that occurred in 2019. The investigative finding of that case was unsubstantiated; and therefore, no disciplinary action was taken.

(c) The SLRDSC Handbook outlines the facility disciplinary procedure as follows; "the Detainee has a right to a disciplinary hearing before an impartial hearing officer or committee who were not involved in the claimed violation or charges. Detainees charged with rule violations are scheduled for a hearing as soon as practicable, but no later than seven days, excluding weekends and holidays, after the alleged violation. Detainees are notified of the time and place of the hearing at least 24 hours in advance of the hearing. Detainees have the right to written notification of the specific alleged violations twenty-four (24) hours prior to the hearing. The hearing may be held within 24 hours with the detainee' consent. The right to waive a hearing provided that the waiver is documented and reviewed by the facility Warden or his designee."

The SLRDSC Handbook also states that, "SLRDSC shall have an IDP or a one-person Disciplinary Hearing Officer (DHO) to adjudicate detainee incident reports. The panel shall not include the reporting officer, the investigating officer, any member of the referring [Unit Disciplinary Committee] UDC, or anyone who witnessed or was directly involved in the incident. The IDP has authority to: Conduct hearings on all charges and allegations; Call witnesses to testify; Consider written reports, statements, physical evidence, and oral testimony; Hear pleadings by detainee and staff representative; Make findings that the detainee did or did not commit the rule violation(s) or prohibited act(s) as charged, based on the preponderance of evidence; Impose sanctions as listed and authorized in each category. The UDC or IDP will advise the detainee in a language or manner the detainee understands before the hearing of his or her right to: Remain silent at any stage of the disciplinary process; Due process, including a UDC hearing (or IDP hearing if SLRDSC does not have a UDC) within 24 hours of the end of the investigation. If there is a UDC hearing, then the IDP hearing must be held within 48 hours after the conclusion of the UDC hearing Attend the entire hearing (excluding committee deliberations). If security considerations prevent the detainee's attendance, the committee must document the security considerations Present statements and evidence in his or her own behalf Have language services to be able to participate meaningfully in the hearing Appeal the committee's determination through the detainee appeal process or waive the right to appeal. The duration of sanctions shall be within established limits. Sanctions range from the withholding of privilege(s) to segregation. Time in segregation or the withholding of privileges after a hearing shall not exceed 30 days per violation, except in extraordinary circumstances, such as violations of offenses 101 through 109. The Unit Disciplinary Committee (UDC) shall further investigate and adjudicate the incident and may impose minor sanctions."

The SLRDSC Handbook further states, "Detainees shall be allowed to appeal disciplinary decisions through a formal grievance system within 24 hours. No staff member shall harass, discipline, punish, or otherwise retaliate against any detainee for filing a complaint or grievance. All documentation of the hearing will be forwarded to the Warden or his designee for review. The Warden is to review for consistency in punishment, and conformity with policy and regulations. He may on his own motion: a. reverse (overturn) the decision, b. remand (send back) the decision for reconsideration, or c. Modify the sanction imposed, whenever such action is warranted in the record. Under such a review, a sanction imposed by the disciplinary committee may not be increased. If the detainee was found not guilty of an alleged rule violation, the disciplinary report is removed from the detainee'[s] files." The AW was asked to explain the disciplinary process. The AW explained that a disciplinary report is written, a detainee is presented with the report outlining the facility violation and a disciplinary hearing officer holds a hearing and if found guilty the hearing officer gives the detainee disciplinary sanctions. The AW further stated that the detainee has a right to appeal the decision to him, the AW first, and if not satisfied then the detainee can appeal to the Warden.

(d)(e)(f) SLRDSC Policy 2.11 further states, "the disciplinary process shall consider 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 may discipline a detainee for sexual contact with staff only upon 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." When interviewing the AW, he indicated that the medical section would notify the hearing officer of any relevant information regarding a detainee's mental state that may have contributed to the offense. He also stated that no detainee would be disciplined for engaging in consensual sexual contact with a staff member. The AW explained that in the state of Arizona there is no such thing as consensual sexual contact between a security staff member and a detainee. It is against the law for a person with custodial authority over a prisoner to engage in sexual contact. Finally, the AW indicated that no detainee would be disciplined if a report of sexual abuse were made in good faith, but the investigation did not establish enough evidence to substantiate the incident.

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

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

Notes:

(a)(b)(c) SLRDSC Policy 2.11 states, "if during the intake screening assessment, Intake Officers or medical staff screening the detainees will be able to determine if a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, ensure that the detainee is immediately referred to qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow is initiated, the detainee shall receive a health evaluation no later than

two working days from the date of the assessment. 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 Auditor interviewed the Intake Officer who was identified as the person responsible for conducting risk screening. The Intake Officer confirmed that if a detainee discloses that they were previous victims of sexual abuse they will be referred to medical for further evaluation and referral. The Auditor also conducted interviews with both the HSA and an Intake Nurse. The HSA stated that if a detainee were identified as a possible sexual abuse victim or abuser during the intake process, the Intake Officer would inform medical and/or mental health professionals. The HSA further indicated that the Intake Nurse who is always working when ICE detainees are brought in is notified by the Intake Officer when a victim or abuser is identified during the risk screening. The Intake Nurse who is on-site also completes the medical screening right after the intake booking process, well within the two working day timeline. The Auditor interviewed the Intake Nurse and asked how the process is completed. The Intake Nurse explained that if a detainee reports prior sexual victimization or identifies as an abuser, the Intake Officer contacts the nurse via phone and that individual is placed on the mental health list through the company's automated medical management system. When the Auditor interviewed the mental health professional, he confirmed this practice and stated that he would make contact with the detainee within 72 hours. If a detainee is identified as a possible aggressor, the procedure would also be referred to mental health for an evaluation. The Auditor interviewed the nurse assistant who confirmed the practice of being notified and scheduling a follow-up meeting with mental health. The facility reported no instances where an ICE detainee reported prior sexual victimization in the community and required a follow-up meeting with medical or mental health professionals.

§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) SLRDSC Policy 2.11 states that, "detainee victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Emergency medical treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident."

The HSA explained during her interview that all detainees have access to emergency medical treatment and crisis intervention services at the Yuma Regional Medical Center. She stated at the emergency room the detainee would receive the necessary treatment such as emergency contraception and sexually transmitted infections prophylaxis. The HSA also confirmed that the medical treatment received for sexual abuse victims is free of charge regardless of whether the victim names the abuser or cooperates with the investigation. The Auditor reviewed one sexual abuse investigation that involved an alleged inappropriate proposal that was perceived as sexual in nature. Therefore, no emergency medical treatment was necessary in this alleged sexual abuse 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)(e)(f)(g) SLRDSC Policy 2.11 states that, "the Facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. Evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The Facility shall provide such victims with medical and mental health services consistent with the community level of care. Detainee 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 and timely access to all lawful pregnancy-related medical services. Detainee victims are provided emergency medical and mental health services and ongoing care as appropriate, including testing for sexually transmitted diseases and infections, prophylactic treatment, emergency contraception, following-up examinations for sexually transmitted diseases, and referrals for counseling (including crisis intervention counseling). Emergency medical treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The SLRDSC shall attempt to conduct a mental health evaluation of all known detainee-on detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners."

The interview with HSA indicated that any additional tests or treatment would be handled by the attending physician and that the medical staff at the facility would provide the necessary continuity of care. The HSA also stated that the facility Doctor would be consulted regarding all continued medical care and treatment. The HSA stated that the medical and mental health services offered at the facility is consistent with that of the community. She indicated that they would provide the continuity of care for detainee victims of sexual assault as specified by the attending physicians at the hospital and the SLRDSC doctor. Finally, the HSA indicated that if a detainee were identified as an abuser, a referral would be sent to mental health. The mental health professional confirmed this practice during his interview and stated that the detainee would be seen within 60 days. However, he indicated had received no referrals during this audit period. The SLRDSC has reported no incidents of sexual abuse involving ICE detainees requiring medical attention during this audit period. The 2019 investigative case file that was reviewed by the Auditor did not require medical attention or mental health services.

(d) SLRDSC Policy 2.11 states in part that, "Detainee 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 and timely access to all lawful pregnancy-related medical services. During the interview with the HSA, she confirmed that the facility would offer pregnancy and sexually transmitted infection tests. She also stated that timely access and pregnancy information and services would be provided to any female detainee that became pregnant while in custody at the SLRDSC.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) SLRDSC Policy 2.11 states that, "the Facility Administrator will ensure staff conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The Warden shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the Field Office Director, for transmission to the ICE PSA Coordinator." The SLRDSC provided a memo dated April 19, 2022, signed by the Warden stating that "the SLRDSC has not received any complaints of sexual abuse from ICE detainees during this audit period. As a result, there has been no need to implement changes to policy or practice related to sexual abuse prevention. SLRDSC investigates all allegations of sexual abuse, and a sexual abuse incident review is conducted at the conclusion of each investigation." However, one allegation was reported within the audit period and the facility provided no documentation indicating an incident review was conducted. LRDSC Policy 2.11 further states that, "the review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The Warden shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and Field Office Director or his or her designee, who shall transmit it to the ICE PSA Coordinator. The interview with the PSA Compliance Manager indicated that the incident review team looks at procedures, facts, and what may have contributed to the incident. He explained that the team consists of the PREA investigator, Warden, AW, and PREA Compliance Manager. The facility provided a blank sexual abuse incident review form that would be completed at the conclusion of every incident review. The document lists considerations such as race, ethnicity, LGBTQ, and gang affiliation. The interview with the AW indicated that an incident review would be conducted at the conclusion of every sexual abuse investigation. Furthermore, the AW indicated that the facility would conduct an annual review of all sexual abuse investigations and incident reviews to improve sexual abuse intervention, prevention, and response. The AW also indicated that the facility would prepare a negative annual report if the facility had not received any reports of sexual abuse.

Did Not Meet (a)(b)(c): The facility advised there were no allegations reported within the audit period; however, one investigation was conducted in 2019 on an allegation reported. The Auditor was provided no documentation to indicate an incident review was conducted. To become compliant, the facility must conduct an incident review of the allegation reported in 2019, meeting all requirements outlined in subpart (b) and provide documentation to the Auditor upon completion. The facility policy states that, "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 provided to the facility administrator and Field Office Director or his or her designee, who shall transmit it to the ICE PSA Coordinator." The facility has provided a negative report indicating no instances of sexual abuse during the prior 12 months audit period. However, the Auditor has received no evidence that the report has been provided to the FOD or the agency PSA Coordinator. The facility must send the negative report to the FOD and provide evidence that the documentation has been sent or received.

§115.87 - Data collection.

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

Notes:

SLRDSC Policy 2.11 states that, "all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling, shall be maintained in the PREA Program Manager's office in a locked file cabinet, consistent with the confidentiality requirements of the Detention Standards on "Medical Care" and "Detention Files." The interview with the PSA Compliance Manager indicated that all sexual abuse case files are kept in the Operations Lieutenant's Office, in a locked cabinet. The Operations Lieutenant is a facility investigator.

§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)(i) The Auditor was provided full access to and observed all areas of the SLRDSC without restriction. The Auditor received all requested documents or copies of relevant materials. The Auditor was also permitted to conduct all interviews in a private setting with the SLRDSC staff and detainees.

(e) The Auditor was provided relevant documentation to complete a thorough audit of the facility prior to the on-site visit, during the visit, and upon request during the post audit period.

(j) Audit notices were posted in the Holding Room which explained that detainees, staff, or any other interested party were permitted to send the Auditor confidential correspondence through the Creative Corrections, LLC mailing address. No correspondence was received.

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:	33
Number of standards not met:	5
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Ron Kidwell 8/25/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 8/25/2022

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 8/25/2022

Assistant Program Manager's Signature & Date