PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Barbara A. King	**Organization:**	Corrective 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:	Philadelphia Field Office
Field Office Director:	Simona Flores
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	114 N. 8th Street, Philadelphia, Pennsylvania 19107
Mailing address: *(if different from above)*	N/A

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	York County Prison		
Physical address:	3400 Concord Road, York, Pennsylvania 17402		
Mailing address: *(if different from above)*	N/A		
Telephone number:	717-840-7580		
Facility type:	IGSA		
Facility Leadership			
Name of Official/Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	717-840-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Population Manager/PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	717-840-(b) (6), (b)

AUDIT FINDINGS

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS:

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

The Prison Rape Elimination Act (PREA) audit of the York County Prison (YCP) was conducted on May 21-23, 2019, by lead auditor Barbara King and team member (b) (6), (b) (7)(C) certified Department of Justice (DOJ) PREA Auditors through Creative Corrections, LLC. York County Prison is a county jail facility operated by York County and overseen by the Prison Board of Inspections. The Prison Board of Inspections consists of the Sheriff, District Attorney, County Commissioners, County Controller, and a Judge. The facility has a contract with U.S. Immigration and Customs Enforcement (ICE) for the housing of both adult male and female detainees. The facility's Department of Homeland Security (DHS) PREA incorporation date is December 2016. The purpose of the audit was to determine compliance with the Department of Homeland Security (DHS) PREA Standards for a Subpart – A facility. This was the first DHS ICE PREA audit of the facility. The audit period covered the previous twelve months from May 21, 2018 through May 23, 2019.

On May 1, 2019, External Review and Analysis Unit (ERAU) Inspections and Compliance Specialist (b) (6), (b) (7)(C) notified the Lead Auditor that the facility documents were available to review on the ICE Sharepoint. ERAU is an entity within the ICE Office of Professional Responsibility (OPR). The documentation included the facility's Pre-Audit Questionnaire (PAQ), agency policies, facility's policies, and other pertinent documents. The PAQ and supporting documentation were organized with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form and within exhibit folders for ease of auditing. The facility's policies that provide direction for PREA are:

- Prison Sexual Abuse and Assault Prevention and Intervention (SAPPI)
- LGBTI (Lesbian, Gay, Bisexual, Transgender, and Intersex)
- Inmate Classification System
- Inmate Compliant Review System (Grievance Procedures)
- Intake Processing
- Personnel
- Case Records
- Searches
- C,J-B-04 Federal Sexual Abuse Regulations - PrimeCare Medical, Inc.
- YCP-B-05 Response to Sexual Abuse – PrimeCare Medical, Inc.

All the documentation, policies, and PAQ were reviewed by the Lead Auditor. The Auditor communicated with the ERAU Team Lead (b) (6), (b) (7)(C) requesting further documentation for clarification and review on May 15, 2019. Responses to the request were provided on May 16, 2019 by the ERAU Team Lead with notice that most of the comments would need to be addressed onsite. Facility staff provided additional documentation during the onsite portion of the audit, and the Auditor received additional audit documentation materials after the onsite audit through the ICE Sharepoint. The Auditor also reviewed the facility's website. A tentative daily time schedule was provided by the ERAU Team Lead for the onsite audit on May 8, 2019.

Before the start of the audit, the Auditors met with agency and facility staff. The Team Lead opened the entry briefing at 8:00 am on the first day of the onsite visit. In attendance were:

(b) (6), (b) (7)(C)	Acting Section Chief, Office of Professional Responsibility (OPR)/ERAU, ICE
(b) (6), (b) (7)(C)	Inspections and Compliance Specialist, OPR/ERAU, ICE
Clair Doll	Warden
(b) (6), (b) (7)(C)	Deputy Warden of Security
(b) (6), (b) (7)(C)	Population Manager/ Prevention of Sexual Assault (PSA) Compliance Manager
(b) (6), (b) (7)(C)	Deputy Warden of Centralized Services/PREA Coordinator
(b) (6), (b) (7)(C)	Assistant Field Office Director (AFOD) / ERO PREA Field Coordinator
(b) (6), (b) (7)(C)	Detention and Deportation Officer (DDO), ICE
(b) (6), (b) (7)(C)	DSM, ICE
(b) (6), (b) (7)(C)	Correctional Officer
(b) (6), (b) (7)(C)	Commander, PREA Lieutenant
(b) (6), (b) (7)(C)	Supervisory Detention and Deportation Officer (SDDO), ICE
Barbara King	PREA Auditor, Creative Corrections, LLC.
(b) (6), (b) (7)(C)	PREA Auditor, Creative Corrections, LLC.

Brief introductions were made and the detailed schedule for the audit was covered. The Lead Auditor provided an overview of the onsite audit process and methodology used to demonstrate PREA compliance. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to ascertain whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, additional onsite documentation review, and conducting both staff and detainee interviews. It was shared that one correspondence was received from a detainee. If the detainee is still housed at the facility, the Auditor would conduct an interview with the detainee. The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific category) including an alpha and housing listing of all detainees housed at the facility, lists of staff by duty position and shifts, lists of detainees for specific categories to be interviewed, list of staff who perform risk assessments, and a list of volunteers/contractors onsite during the audit. The Lead Auditor informed the staff that an Auditor would observe the intake and classification process.

A facility tour was completed by the Auditors with key staff. All housing units were toured, as well as, program areas, service areas, food service, control center, admissions/intake, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or provided services were observed by the Auditors. During the tour, the Auditors made visual observations of the program/service areas and housing units including bathrooms, officers post sight lines, and camera locations. Sight lines were closely examined as was the potential for blind spots throughout the areas where the detainees are housed or have accessibility. The Auditors spoke to random staff and detainees regarding PREA education and facility

practices during the tour. Review of the housing unit logbooks was conducted to verify staff rounds for security staff and supervisors. Key facility staff during the audit included the Warden, PSA Compliance Manager, Deputy Warden of Centralized Services /PREA Coordinator, and Deputy Warden of Security, Commander/PREA Lieutenant, and AFOD. All facility staff were very cooperative and informative during the audit process.

The current York County Prison was opened in 1997 which replaced the original York County Prison that was opened in 1907. The facility has two buildings; the main facility and the work release building. The facility had numerous expansions: in 1992 added four housing blocks; in 1998 additional of a housing wing; in 2006 main medical and kitchen expansion; and in 2012 the addition of a work release center. The facility consists of a single and two-story building design that is approximately 600,000 square feet. The facility has a design capacity of 2,673. York County Prison incorporates several different types of housing units which include dormitories, linear housing units, and direct and indirect supervision housing units. There are 4 single occupancy cell- housing units; 18 dorm housing units; 9 multiple occupancy cell housing units; and 217 administrative and disciplinary segregation cells. The custody level- ranges are high, medium, and low. The facility houses county inmates that may be pretrial offenders awaiting trial or those already sentenced to one year or less by the Court of Common Pleas. The facility also houses county juveniles. Inmates from the Pennsylvania Department of Corrections and Pennsylvania Board of Probation and Parole are also housed. On the first day of the audit, the total facility population was 1,993 with 714 ICE detainees.

The ICE contract for the housing of detainees is only for adult male and female detainees. No juvenile or family detainees are held at this facility. The 714 ICE detainees on the first day of the audit consisted of 33 female and 681 male. The average detainee population for the last twelve months was 750. The average time in custody is 60 days. The detainees are housed throughout the facility's housing units. The top three nationalities of detainee population are Mexican, Guatemalan, and El Salvadoran.

The facility has contracts for healthcare with PrimeCare Medical, commissary with Keefe Commissary, religious services with Good News Ministry, and education with LIU. Volunteers provide religious services, programming, and drug and alcohol intervention.

"The mission of the York County Prison is to maintain a safe, secure, environment for a diverse population of incarcerated individuals, staff, and visitors. We are dedicated to implementing innovative methods of security and working with our community partners to provide quality education and evidenced-based treatment programs to increase the probability of successful community reentry. "

Entrance in the facility for staff and visitors is through the front entrance. The facility administrative offices are to the right in the administrative section of the facility. To enter the secure section of the building, entrance is through a sally port adjacent to the central control center and controlled by the central control center. The housing consists of:

North Block – male general population. Consists of 6 double occupancy housing units (NA -28, NB-32, NC-32, ND-32, NE-14, NF-14) with a maximum capacity of 152. Housing Unit NF has a mental health classification.
South Block – male pre-classification status. Consists of 6 double occupancy housing units (SA -32, SB-32, SC-32, SD-28, SE-14, SF-14) with a maximum capacity of 152. Housing Unit SF houses mental health needs.
East Block – male general population. Consists of 6 double occupancy housing units (EA -36, EB-32, EC-32, ED-36, EE-16, EF-16) with a maximum capacity of 168. Unit EE (veterans)and EF (juveniles) housed no detainees.
New North Block – male general population. Consists of 6 double occupancy housing units (NNA -36, NNB-32, NNC-32, NND-28, NNE-14, NNF-14) with a maximum capacity of 156.
New South Block – male general population. Consists of 6 double occupancy housing units (SSA -36, SSB-32, SSC-32, SSD-36, SSE-16, SSF-16) with a maximum capacity of 168.
Busy Area Unit –Consists of 4 housing areas (OS2 Medical Beds – 9, Busy Cells (3 mental health holding, 3 high risk overflow, 3 stepdown form crisis)-20, HC-90, TDY-40) with a maximum capacity of 153.
Cross Hall Area – segregation population. Consists of 5 housing units (A-8 medical step down, B-8 mental health, C-8 mental health, D-12, E-8) with a maximum capacity of 44.
Bravo Dorm Block – female general population. Consists of 4 housing dorms (IB1-56, IB2-56, IB3-56, IB4-56) with a maximum capacity of 224. Dorm IB2 is used for pre-classification.
Charlie Dorm Block – male general population. Consists of 4 housing dorms (IC1-56, IC2-56, IC3-56, IC4-56) with a maximum capacity of 224.
Delta Dorm Block - male general population. Consists of 3 housing dorms (A-32, B-32, C-16) with a maximum capacity of 80. C Dorm is for protective custody.
Echo Male Behavior Adjustment Block - male general population. Consists of 3 single cell housing units (A-32, B-32, C-16) with a maximum capacity of 80. C Unit is for protective custody.
F Block – male general population. Consists of 11 dorm housing units (FA -14, FB-14, FC-14, FD-14, FE-16, FF-14, FG -14, FH-14, FI-14, FJ-16, FK-30) with a maximum capacity of 174.
M Block – male general population pre-classification housing. Consists of 6 dorms (MA -60, MB-60, MC-60, MD-60, ME-60, MF-60) with a maximum capacity of 360. Housing Units MA, MB, and MC are ICE pre-classification.
Kitchen Dorm – male general population dorm that houses the kitchen workers. Maximum capacity of 60.
Work Release Unit – male general population dorm that is approved for work release. Maximum capacity of 152. No detainees are housed in this unit.
H Block – female housing. Consists of 4 double occupancy housing units (A-12, B-32, C-32, D-12) with a maximum capacity of 88. Unit A is for females with special needs, Unit B is general housing. Unit C is for pre-classification. Unit D is for medical, isolation, and mental health.
Female Behavior Adjustment Block – female general housing. Consist of 9 single cells with a maximum capacity of 9.
L Block – female minimum housing dorms (A-24, B-24) with a maximum capacity of 48.
G Dorm – female general housing dorm with a maximum capacity of 98. No detainees were housed.

The North, South, East, New North, New South and H Block all have dayrooms with indirect supervision. There is a correctional officer located in the control booth in each housing unit with other correctional officers providing rounds within the housing unit. The dayrooms are open from 6:00 am to 11:00 pm and contain telephones. The cells have toilets and showers are located on each floor of the housing units. PREA information was posted on bulletin boards in the hallways, which was not accessible to the detainees. The showers provided no privacy and allowed cross gender viewing.

The dorms have direct supervision with an officer's post within the unit. Within the dayroom areas of the dorms are telephones and PREA information posted on the bulletin boards. The toilet and shower areas allow cross gender viewing. The PREA information on the bulletin boards were mostly covered with other postings.

Other housing units (segregation, medical, special housing) are indirect supervision with staff making rounds through the units. PREA information was posted on bulletin boards in the hallways which was not accessible to the detainees. The showers provided no privacy and allowed cross gender viewing. For the restricted housing area, a phone on a mobile unit is brought to the cell for the detainee to utilize or if there is a unit dayroom, the detainee may utilize the phone in the dayroom, if dayroom time is permitted. The admissions area has four holding cells and a change-over room. The large holding cell and change over rooms allow cross gender viewing of the toilets. Detainees do not remain in holding cells longer than 12 hours.

(b) (7)(E)
Phones are available for the detainees which allow reporting accessibility. The phones, which includes the Hotline, are only available for reporting from 9:00 am to 10:00 pm when the phones are on. The reporting hotline number of *55 is not posted on all phones and is very small on others. In the dorms and in the hallways of celled housing units, the PREA information posters/brochures are posted on bulletin boards which include the ICE Zero Tolerance Poster, PREA Audit Notices, the ICE Sexual Abuse and Assault Awareness pamphlet, memo on reporting methods including addresses and numbers, how to report outside the facility, and foreign consulates with addresses and phone numbers. Although the PREA information is posted, most of the postings are reproductions that are hard to read and decreased from original size which makes them hard to read. The PREA information is also covered by other postings on most bulletin boards. The detainees have access to tablets which allows them to file a grievance, contact ICE, contact the local ICE officer, and contact family through emails. The tablets require a pin number to use. The tablet also has the ICE PREA information and video available to them. There are signs posted on the female housing units entry doors that state, "When entering this area all males must announce themselves."

Areas where detainees work are the kitchen, laundry area, and throughout out the facility as sanitation janitors. The laundry area is an open area with no blind spots. (b) (7)(E) (b) (7)(E)
The kitchen is staffed with food service staff on three shifts. There is a kitchen supervisor and officers that supervise the area. Meals are prepared in the kitchen and delivered to the housing units. Detainees are directly supervised in the kitchen. The Auditors identified (b)(7)(E)
. The coolers and freezers are accessible to the detainees and are not locked. (b) (7)(E)

During the tour, the Auditors reviewed housing unit logs for unannounced rounds by supervisors and correctional officers housing unit rounds. The supervisor rounds are noted within a notebook in each housing booth or at an officer's desk. Supervisors make rounds each shift and the administration rounds are required monthly by the duty officer. The correctional officer housing unit rounds are digital scanned rounds and recorded electronically. Also, during the tour, the Auditors identified sight line concerns throughout the facility. In general, there is visible cross gender viewing of toilets and showers throughout the facility. The Auditors observed detainees showering with no privacy and utilizing the toilets performing bodily functions. A breakdown of the cross-gender viewing, blind spots, and lack of PREA information identified:

Admissions Area: cross-gender viewing of the toilet in the large holding cell and in the change-over room
(b) (7)(E)
; first bathroom has toilets and showers in full view; bathroom near D dorm has toilet and shower in full view; bathroom near I Dorm has the first toilet on each side and the showers in full view; and bathroom by F Dorm has toilets and showers in full view. (b) (7)(E)

OS2 (Old Segregation): shower has visibility
(b) (7)(E)
Hallway Cells: the toilets in the four cells can be viewed.
H Block: In the A Unit the showers are visible and there was no PREA information posted. In the B Unit the showers are visible, cell toilets can be seen by staff and the control booth staff and there was no PREA information posted. In the C Unit the showers are visible, cell toilets can be seen by staff and the control booth staff and there was no PREA information posted. In the A Unit the showers are visible and there was no PREA information posted. T(b) (7)(E)

Female Behavior Adjustment Block: the shower curtains were not high enough allowing viewing of female breasts while showering.
Cross Hall Area: Segregation A toilets visible, Segregation B toilets visible, Segregation C toilets visible.
New North Block: Unit NNA the showers are visible; the frosting on the window is not adequate. Unit NNB-32 the showers are visible; the frosting on the window is not adequate. Unit NNC the showers are visible; the frosting on the window is not adequate, and toilets are visible. Unit NND the bathrooms are visible; the privacy walls are too short. Unit NNE the showers are visible; the frosting on the window is not adequate. Unit NNF the showers are visible; the frosting on the window is not adequate, and toilets are visible.
East Block: Unit EA the showers are visible; the frosting on the window is not adequate, and toilets are visible; the privacy walls are too short. Unit EB the showers are visible from the hallways; the frosting on the window is not adequate, and toilets are visible. Unit EC the showers are visible; the frosting on the window is not adequate, and toilets are visible. Unit ED toilets are visible. Unit EE and EF housed no detainees.
Delta Dorm Block: Unit A the cell toilets are visible, and the shower curtains are inadequate. The shower in the middle of the unit like others, there is no curtain, so the detainee is totally exposed. Unit B-32, the cell toilets are visible, and the shower curtains are inadequate. Unit C the shower curtains are inadequate.
Bravo Dorm Block: Dorm IB1 toilets and showers are visible and the video visit area has a blind spot. Dorm IB2 the toilets and showers are visible. Dorm IB3 houses no detainees.
M Block: Dorm MA the showers and toilets allow visibility, (b) (7)(E) and cameras allow cross gender viewing during clothing changes. Dorm MB the showers and toilets allow visibility, (b) (7)(E), and cameras allow cross gender viewing during clothing changes. Dorm MC the showers and toilets allow visibility, blind spot in the video visitation area, and cameras allow cross gender viewing during clothing changes. Dorm MD the showers and toilets allow visibility, blind spot in the video visitation area, and cameras allow cross gender viewing during clothing changes. Dorm ME the showers and toilets allow visibility, (b) (7)(E) area, and cameras allow cross gender viewing during clothing changes. Dorm MF the showers and toilets allow visibility, blind spot in the video visitation area, and cameras allow cross gender viewing during clothing changes.
New South Block: Unit SSA the showers and toilets are visible. Unit SSB the showers and toilets are visible. Unit SSD the showers and toilets are visible. No PREA information posted in the housing units.

Echo Male Behavior Adjustment Unit: Unit A showers are visible and the recreation area has a blind spot in left front corner. Unit B toilets are visible, (b) (7)(E) and papers need to be removed from the vision panels. Dorm C the shower curtains are not adequate. The facility had created a prototype shower panel for the first shower.
South Block: Unit SA showers are visible on each level. Unit SB showers visible on each level and from the hallways. Unit SC toilets and showers are visible. Unit SD the toilets and showers are visible. Unit SE the showers and toilets are visible. Unit SF the toilets and showers are visible.
South Hallway Gym: (b) (7)(E) . The post orders state officers are to be posted in the gym. (b) (7)(E) .
Kitchen: (b) (7)(E)

Kitchen Dorm: The showers are visible. (b) (7)(E)
ICE Property Room and Officers: (b) (7)(E)
Triage/X-Ray/Storage Room: (b) (7)(E)
(b) (7)(E)

(b) (7)(E)

All cameras are viewed at the central control center. The central control center has 10 monitors that each provide 16 camera views. The camera footage can be viewed by the shift commander, intelligence office, Warden, Deputy Wardens, and security supervisors of Lieutenant or above. The housing unit control booth has viewing of the cameras in their housing units and hallways through three monitors that each provide six views. The Auditor observed the camera monitoring displays in the control center and the housing unit control booths. (b) (7)(E) Cameras operate on a 120-day recording system and are stored on the facility's server system. The Warden and Facility Manager have access to the video footage.

All required facility staff and detainee interviews were conducted on-site during the three-day audit. Thirty-six formal detainee interviews were conducted, and 18 detainees were informally interviewed during the facility tours, (7.6% of the 714-detainee population). Detainees were selected randomly by the Auditor from different housing unit and from the lists provided for the specialized interviews. Random detainee interviews from different housing units (18), Limited English Proficient (11), Detainees with Disabilities (4), Reported Sexual Abuse (2), and Reported Sexual Abuse History (1) were interviewed. Two detainees refused interviews. The Auditors utilized Language Services Associates (LSA) through the Creative Corrections LLC contract for translation services for all limited English proficient detainees interviewed. The language line was utilized for detainees that spoke Spanish and Mandarin. Although the facility indicated they had no detainees with disabilities, the Auditors found randomly two detainees that could not read or write and two detainees with low cognitive skills. Interviews were not conducted for Who Filed a Grievance, Placed in Segregation Housing for Risk, and Transgender/Intersex. The facility did not have any detainees housed that were in these categories. The facility does not house juvenile detainees. There were no detainees placed or housed in segregation housing for risk during the audit period. There were no identified transgender/intersex detainees at the facility during the onsite audit. And no detainee that had filed a grievance was still housed.

A total of 31 staff were formally interviewed and additional 12 informal staff interviews were conducted during the facility tours (6.3% of the 665 staff who may have contact with detainees). Staff were randomly selected for the Security Staff, Including Line Staff and First Line Supervisors interviews from each of the three shift rosters: security staff (14), non-security department staff (2), and an SDDO officer (1). Additionally, specialized staff were interviewed including the Warden (1), PSA Compliance Manager (1), Medical and Mental Health (2), Non-Security Contractors (3), Investigator (1), Training Supervisor (1), Classification Supervisor (1), Intake staff (1) and Non-Security Staff First Responder (1). There were no volunteers available during the onsite audit to interview. The Administrative/Human Resources (1) and the Grievance Coordinator (1) were interviewed over the phone after the onsite audit. Two staff refused interviews.

There were eleven allegations reported during the audit period; nine were closed and two were open cases. Of the nine closed allegations, three were staff-on-detainee, four were detainee-on-detainee, and two were inmate-on-detainee. The investigative outcomes of the staff-on-detainee allegations of sexual harassment were found to be: one substantiated and two unfounded. Three of the detainee-on-detainee allegations were sexual harassment, of which one was unsubstantiated and two were substantiated. The sexual abuse detainee-on-detainee allegations was substantiated. The inmate-on-detainee allegations consisted of one allegation of sexual harassment and the other allegation was sexual harassment and sexual abuse. The allegation of sexual harassment was substantiated; in the sexual harassment/sexual abuse allegations, the sexual harassment was substantiated, and the sexual abuse was unsubstantiated. The PAQ indicates that four of the allegations were referred to outside law enforcement for investigation, Pennsylvania State Police (PSP). Upon review of the investigation files for the audit period, only two were referred to PSP. The ICE OPR was notified of all the allegations as documented in the investigation files. The PSA Compliance Manager/Investigator stated ICE did not complete any investigations. This could not be confirmed through the investigation files. There were no cases referred for prosecution. A review of all nine closed investigations was conducted. The one case of staff-on-detainee sexual harassment that was substantiated was overturned during the incident review to unsubstantiated.

The Auditors also reviewed staff personnel files, staff training records, and detainee files. Two detainee intakes were observed by the Lead Auditor in the intake/processing area for a new detainee intake. A risk screening and classification was observed by the team Auditor.

An exit briefing was conducted by the Auditors at the completion of the on-site audit. The following participants were in attendance:

- (b) (6), (b) (7)(C) Acting Section Chief, OPR/ERAU, ICE
- (b) (6), (b) (7)(C) Inspections and Compliance Specialist, OPR/ERAU, ICE
- Clair Doll Warden
- (b) (6), (b) (7)(C) Population Manager/ PSA Compliance Manager
- (b) (6), (b) (7)(C) AFOD / ERO PREA Field Coordinator
- (b) (6), (b) (7)(C) DSM, ICE

- (b) (6), (b) (7)(C) Commander/PREA Lieutenant
- (b) (6), (b) (7)(C) SDDO, ICE
- Barbara King PREA Auditor, Creative Corrections, LLC.
- (b) (6), (b) (7)(C) PREA Auditor, Creative Corrections, LLC.

While the Auditors could not give the facility a final finding per standard, the Auditors did provide a preliminary status of their findings: 19 standards met compliance, 21 standards did not meet compliance, and 1 standard was non-applicable. Recommendations were shared with the facility that will be addressed under the appropriate standard in the narrative section. The Auditor suggests the facility continue to expand their operating policies and procedures including detailing the procedures demonstrated throughout the audit, which would provide written procedural directives for staff. The policies are more policy statements of the standards than procedures.

The Auditors shared with those in attendance the appreciation of the hospitality received and for the professionalism provided by all staff during the visit. The Auditors observed interactions between staff and detainees in a positive manner throughout the onsite audit. The Auditors shared with the Warden and the facility's administration the feedback received from the detainee population regarding the facility's operations, the positive interviews with staff, and the professionalism demonstrated by staff during the audit. The Auditors thanked the York County Prison, Warden Doll, PSA Compliance Manager, and all the facility staff for their work and commitment to the Prison Rape Elimination Act.

After the onsite audit, additional information was provided by the facility and provided to the Auditor through the ICE Sharepoint. The Auditor received another correspondence after the onsite audit. The second correspondence was forwarded to the EARU Team Lead for action. The Auditor was informed the correspondence was not from a detainee; it was from an inmate. The correspondence was shared with the AFOD for review and action.

SUMMARY OF AUDIT FINDINGS:

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

Exceeds Standard: 0

Meets Standard: 19

115.11 Zero Tolerance of Sexual Abuse
115.13 Detainee Supervision and Monitoring
115.18 Upgrades to Facilities and Technologies
115.35 Specialized Training: Medical and Mental Health Care
115.51 Detainee Reporting
115.53 Detainee Access to Outside Confidential Support Services
115.54 Third Party Reporting
115.62 Protective Duties
115.63 Reporting to Other Confinement Facilities
115.65 Coordinated Response
115.66 Protection of Detainees from Contact with Alleged Abusers
115.67 Agency Protection Against Retaliation
115.68 Post-Allegation Protective Custody
115.72 Evidentiary Standard for Administrative Investigations
115.73 Reporting to Detainees
115.82 Access to Emergency Medical and Mental Health Services
115.83 Ongoing Medical and Mental Health Care for Sexual Abuse
115.87 Data Collection
115.201 Scope of Audit

Does Not Meet Standard: 21

115.15 Limited to Cross-Gender Viewing and Searches
115.16 Accommodating Detainees with Disabilities and Detainees Who Are Limited English Proficient
115.17 Hiring and Promotion Decisions
115.21 Evidence Protocols and Forensic Medical Examinations
115.22 Policies to Ensure Investigation of Allegations and Appropriate Agency Oversight
115.31 Staff Training
115.32 Other Training
115.33 Detainee Training
115.34 Specialized Training: Investigations
115.41 Assessment for Risk of Victimization and Abusiveness
115.42 Use of Assessment Information
115.43 Protective Custody
115.52 Grievances
115.61 Staff and Agency Reporting Duties
115.64 Responder Duties
115.71 Criminal and Administrative Investigations
115.76 Disciplinary Sanctions for Staff
115.77 Corrective Action for Contractors and Volunteers
115.78 Disciplinary Sanctions for Detainees
115.81 Medical and Mental Health Assessments, History of Sexual Abuse
115.86 Sexual Abuse Incident Reviews

Not Applicable Standard: 1

115.14 Juvenile and Family Detainees

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	0
Number of standards met:	19
Number of standards not met:	21
Number of standards N/A:	1

PROVISIONS

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

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

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

Notes:

(c): The facility has a written policy, Sexual Abuse Assault Prevention and Intervention (SAAPI), stating York County Prison has a zero-tolerance standard for incidents of sexual harassment and sexual assault. All allegations of sexual harassment and assault will be investigated thoroughly in order to provide prompt health intervention to those involved, prosecution or disciplinary action against the perpetrators, while being sensitive to the needs of the victim. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and harassment. The policy provides definitions of sexual abuse and general PREA definitions. Through observation of bulletin boards, posters, educational handouts, review of detainee handbooks, and interviews with staff and detainees; it appears that the facility is committed to zero tolerance of sexual abuse, sexual assault, and sexual harassment. The zero-tolerance statement from the policy is publicly posted on the facility's website.

(d): The facility has a PREA Coordinator designated as the Deputy Warden of Centralized Services. The Population Manager has been designated as the Prevention of Sexual Assault (PSA) Compliance Manager. The PREA Coordinator reports directly to the Warden and the position's responsibilities include developing, implementing, and overseeing the facility's plan to comply with the PREA standards. The PREA Coordinator is the point of contact for the agency's PSA Coordinator. THE PSA Compliance Manager reports to the PREA Coordinator. The PSA Compliance Manager stated the position's role is to track and log all allegations, initiate the investigation process, provide training, assign cases, track investigation process, and monitor retaliation. The PSA Compliance Manager stated she has ample time to manage the facility's PREA related responsibilities along with the PREA Coordinator. During the interview with the PSA Compliance Manager, she was knowledgeable of the facility's PREA policies and procedures and her responsibilities for coordinating the facility's efforts to comply with the PREA standards.

§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): The facility has developed a staffing plan that provides sufficient supervision of detainees which includes video monitoring. The Warden stated the staffing analysis was developed two years ago with the assistance of the Pennsylvania Department of Corrections (PDOC) and is reviewed annually. The PDOC requires staffing ratios of 1 staff to 60 detainees/inmates for the dorms that are level 1 and 2 security level. The high level 2 and 3 security housing blocks require three officers; one in the control booth and two officers making rotating rounds through the block. Part of the staffing analysis includes the review of the post orders, rounds requirement, and video monitoring needs stated the Warden. The Warden stated the staffing plan is reviewed annually at the end of the year as part of the year end plan with input from the Interdisciplinary Team which identifies vulnerabilities. The annual staffing analysis is reviewed by the PDOC and approved by the Prison Board. The last review occurred on January 10, 2019 with previous reviews conducted on October 5, 2017 and February 20, 2018. The 2019 Staffing Analysis had authorized positions of 584 and showed 562 positions were filled. The relief factor for the 7-day posts was 1.73, 6-day posts was 1.51, and 5-day posts was 1.24. Which then identified required staff needed for correctional officers were 447.15 and 36.33 for sergeants. The facility's security staff is comprised of 494 staff; 408 males and 86 females. The last review identified additional cameras were needed in the kitchen area. This was identified through the Safety Commission, Security Review Committee, Cost Savings Committee, and staff from all departments as stated by the Warden. A review of the PAQ indicated the facility's staffing level is 665 staff that may have recurring contact with detainees. Security staff work three 8-hour shifts; 8:00 am to 4:00 pm (day), 4:00 pm to 12:00 am (second), and 12:00 am to 8:00 am (night). Sufficient supervision of detainees was observed through on-site observations of security, program, and medical staff supervising and interacting with detainees. The Auditors reviewed daily security shift rosters/assignments for all shifts and determined the facility is ensuring staffing levels are being maintained to ensure sufficient supervision of the detainees. Through the review of the sexual abuse incident reviews by the Auditors, the staffing levels at the time of the incident are reviewed and staffing was found adequate in all reviews.

The facility supplements staff supervision through a video management system of 375 cameras. The cameras have no sound capability and some of the newer cameras are able to pan, tilt, and zoom. (b) (7)(E) [redacted] All cameras are viewed at the central control center. The central control center has 10 monitors that each provide 16 camera views. The camera footage can be viewed by the shift commander, intelligence office, Warden, Deputy Wardens, and security supervisors of Lieutenant or above. The housing unit control booth has viewing of the cameras in their housing units and hallways through three monitors that each provide six views. (b) (7)(E) [redacted]

(b): The General and Specific Post Orders outline the responsibilities of detainee supervision. There is at least one assigned officer to each housing unit who provides direct or indirect supervision of detainees. Direct supervision is provided in the dorms where an officer's post is within the dorm. The celled housing units are indirect supervision with an officer's control booth that is staffed, and correctional officers assigned to the unit that make random rounds within the housing units in the block. The Warden and PSA Compliance Manager explained the rounds requirements. For general housing, rounds are required hourly during the day and second shifts when the detainees are not locked down and every 30 minutes on night shift or when detainees are locked down. For special housing, medical, and segregation; rounds are required every 15 minutes. Rounds are documented digital through a hand-held scanner that scans the bar code on the wall. If the Wi-Fi is not working, rounds are logged on daily report and housing unit logbooks. The Warden indicated that all posts are filled daily. If there is a staff shortage, coverage is provided through overtime. Video cameras operate 24 hours a day, 7 days a week and are monitored through the central control center. The security shift supervisor is also required to make a supervision round into each housing area at least once per shift which is also logged into the

specific housing unit logbook, captured digitally, and noted in the supervisor rounds notebook. The Auditors reviewed housing unit logbooks to confirm the practice of rounds and found compliance. The post orders are reviewed on an annual basis. The annual review was completed on January 10, 2019, with previous reviews conducted on October 5, 2017 and February 20, 2018 by the facility administrator and unit management. All post orders reviewed by the Auditors have been reviewed and approved within the previous year.

(c): The facility's staffing plan was developed with consideration to generally accepted detention and correctional practices; any judicial finding of inadequacy; the physical layout, composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the findings and recommendations of sexual abuse incident review reports, and any other relevant factors including but not limited to the length of time detainees spend in facility custody. The staffing plan was developed by the leadership of the facility including the Warden, Deputy Wardens, PSA Compliance Manager with input from the Interdisciplinary Team as stated by the Warden. The Warden and the PSA Compliance Manager indicated that the ICE and PDOC standards are taken into consideration, there were no judicial findings of inadequacy, the physical layout of the facility is considered for cameras and staff coverage, the custody level and classification system is reviewed for housing needs, they review the incidents for patterns or trends, and any findings found through incident reviews, and length of time the detainees spend in custody. The noted findings from the review included the detainees are staying longer in custody because of the court schedules, identified the need for more cameras, and identified F Block as an area with more allegations. Through the Staffing Analysis recommendations; additional cameras have been added, an increase in staffing, created the security office, made policy and procedure changes, and added a PREA lieutenant. The YCP Executive Team and department heads meet weekly to discuss enhancement of supervision and treatment. The Auditors were provided and reviewed the weekly YCP Administrative Meeting Minutes for May 15, 2019 where the Prison Strategic Planning Team covered PREA concerns; staffing including the overtime coverage; and the annual staffing analysis and budget provided to the Prison Board for documentation. A copy of the staffing analysis could not be maintained by the Auditors; however, it was reviewed on-site. Based on the review of the staffing analysis, staffing rosters, and interviews with the Warden and PSA Compliance Manager the Auditors found the facility is maintaining sufficient supervision.

(d): Supervisors and administrative staff conduct unannounced rounds. The security shift supervisor is also required to make a supervision round into each housing area at least once per shift which is also logged into the specific housing unit logbook, captured digitally, and noted in the supervisor rounds notebook. The administration rounds are required monthly by the duty officer. The unannounced rounds are documented in the YCP logbooks in the housing units with the notation of UAR (unannounced rounds). Through reviews of housing unit logbooks and interviews with staff and detainees, it was confirmed that unannounced rounds are done randomly throughout the facility by supervisors on all three shifts. The first line supervisors interviewed indicated that unannounced rounds are accomplished by staggering the round times on a daily basis, and random patterns for housing units, and using different routes and not a routine pattern. Through interviews, staff acknowledged knowing staff are prohibited from alerting other staff members that supervisory staff rounds are occurring; this is provided through shift briefings and training. Supervisors also indicated in the interviews that if a staff member was alerting other staff, training would be conducted immediately with the staff member and progressive discipline action could be started on the employee.

Recommendation: The facility policy and post orders should be expanded to include language that staff are prohibited from alerting others that security inspections are occurring, unless such announcement is related to the legitimate operational functions of the facility.

§115.14 – Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The York County Prison does not house juvenile and family detainees. Review of the PAQ and interviews with the Warden and PSA Compliance Manager confirm the facility does not house juveniles nor family detainee units. A memo to file from the ICE Compliance Shift Commander stated York County Prison does not hold or house ICE juveniles or families. The facility does hold juveniles that are county inmates.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b/d) The facility's SAAPI and Searches policies state staff shall conduct pat-down searches of the same gender inmates/detainees, except in exigent circumstances. In the event a cross-gender pat-down search is required, the staff member shall document the search on an officer's daily report. This report shall be forwarded to the Shift Commander for review and action. Random staff interviewed stated it is common for female staff to pat-down male detainees going to recreation, while working a male housing unit, and during admissions. The Auditors observed female staff conducting pat-down searches on male detainees going to recreation. The facility did not document cross-gender pat-down searches prior to April 9, 2019 stated in the memo to file. The PAQ states not all cross-gender pat-down searches are documented. The memo also stated that security staff were informed of the updated policy that pat-down searches are to be conducted by the same gender through staff email and a memo attached to a paycheck. There was no documentation for the routine cross-gender pat-down searches conducted by female staff on male detainees.

Does Not Meet: The facility has a common practice of allowing female staff to conduct cross-gender pat-down searches on male detainees when going to recreation and when providing supervision in a male housing unit. These cross-gender pat-down searches are not documented. The facility needs to follow the facility policy and standard and eliminate the common practice of cross-gender pat-down searches of male detainees by female staff except in exigent circumstances. When cross-gender pat-down searches occur, the searches are to be documented.

(c) The facility's SAAPI and Searches policies state staff shall conduct pat-down searches of the same gender inmates/detainees, except in exigent circumstances. Random staff interviewed stated that only female staff conduct pat-down on female detainees. Female staff are assigned on each shift to provide pat-down searches on female detainees. This was confirmed through review of the shift rosters.

(e/f) The facility's SAAPI and Searches policies outlines strip searches (physical search and viewing) shall be conducted by correctional officers of the same sex of the inmate/detainee being searched, except in exigent circumstances. Only a licensed medical professional shall conduct body cavity searches. Six random staff interviewed acknowledged knowing that male staff conducted strip search of male detainees going to segregation and during clothes change over. Staff acknowledged they were not aware of any cross-gender strip searches of male or female detainees being conducted. One random detainee interviewed indicated he was strip searched by a male officer with female officers in the area and this is common. Policy also requires the search to be documented on the officer's daily log. Documentation provided demonstrated

that strip searches are documented on a Detainee Strip Search Form. The facility policy and documentation showed the facility conducts strip searches of detainees entering the Behavior Adjustment Unit, medical segregation, and segregation. There was no evidence that cross-gender strip searches or visual body cavity searches occurred at the facility. The facility does not house juveniles.

(g) The facility's SAAPI policy states all prison staff, contractors, volunteers, and visiting officials shall announce their presence when entering a housing unit of the opposite gender as to avoid cross-gender viewing of inmates/detainees showering, performing bodily functions, and changing clothes. The Auditors observed announcements being made while on the tour and during revisits to facility areas. There are signs posted on the female housing units entry doors that states, "When entering this area all males must announce themselves." Staff are also provided training on unannounced rounds to help assure compliance with the standard that limits cross-gender viewing. The majority of the random interviews with detainees stated staff of the opposite gender announce when entering the housing areas. Interviews with random staff acknowledged making announcements and the requirement to make the announcement upon entering a housing unit of the opposite gender. The random staff and detainee interviews indicated the detainees do not have privacy to allow detainees to shower, perform bodily functions and change clothing without employees of the opposite gender viewing them. Male staff interviewed stated they understand the need for privacy and when entering a female housing unit, they keep their head down and not look into the showers or bathrooms and announce male on the block. Ten of the 18 random detainee interviews indicated that staff of the opposite gender can see them showering, using the toilet, and when changing clothes. The cross-gender viewing in the female housing units is a result of the facility policy for the cell doors to be open at all times during the day and second shift to eliminate the need to continue opening and closing the cell doors. In general, there is visible cross-gender viewing of toilets and showers throughout the facility. The Auditors observed detainees showering with no privacy and utilizing the toilets performing bodily functions. (b) (7)(E) [redacted]

Does Not Meet: Throughout the facility there is cross-gender viewing of detainees in showers, utilizing the toilet, and changing clothes. The facility must allow detainees privacy from cross-gender viewing for showering, performing bodily functions, and changing clothes. A breakdown of the cross-gender viewing areas identified by the Auditors:

- Admissions Area: cross gender viewing of the toilet in the large holding cell and in the change-over room
- F Block –first bathroom has toilets and showers in full view; bathroom near D dorm has toilet and shower in full view; bathroom near I Dorm has the first toilet on each side and the showers in full view; and bathroom by F Dorm has toilets and showers in full view.
- OS2 (Old Segregation): shower has visibility
- Hallway Cells: the toilets in the four cells can be viewed.
- H Block: In the A Unit the showers are visible. In the B Unit the showers are visible, cell toilets can be seen by staff and the control booth staff. In the C Unit the showers are visible, cell toilets can be seen by staff and the control booth staff. In the A Unit the showers are visible.
- Female Behavior Adjustment Block: the shower curtains were not high enough allowing viewing of female breasts while showering.
- Cross Hall Area: Segregation A toilets visible, Segregation B toilets visible, Segregation C toilets visible.
- New North Block: Unit NNA the showers are visible; the frosting on the window is not adequate. Unit NNB-32 the showers are visible; the frosting on the window is not adequate. Unit NNC the showers are visible; the frosting on the window is not adequate, and toilets are visible. Unit NND the bathrooms are visible; the privacy walls are too short. Unit NNE the showers are visible; the frosting on the window is not adequate. Unit NNF the showers are visible; the frosting on the window is not adequate, and toilets are visible.
- East Block: Unit EA the showers are visible; the frosting on the window is not adequate, and toilets are visible; the privacy walls are too short. Unit EB the showers are visible from the hallways; the frosting on the window is not adequate, and toilets are visible. Unit EC the showers are visible; the frosting on the window is not adequate, and toilets are visible. Unit ED toilets are visible
- Delta Dorm Block: Unit A the cell toilets are visible, and the shower curtains are inadequate. The shower in the middle of the unit like others, there is no curtain, so the detainee is totally exposed. Unit B-32, the cell toilets are visible, and the shower curtains are inadequate. Unit C the shower curtains are inadequate.
- Bravo Dorm Block: Dorm IB1 toilets and showers are visible. Dorm IB2 the toilets and showers are visible.
- M Block: All the dorms (MA, MB, MC, MD, ME, MF) showers and toilets allow visibility and cameras allow cross gender viewing during clothing changes.
- New South Block: Unit SSA the showers and toilets are visible. Unit SSB the showers and toilets are visible. Unit SSD the showers and toilets are visible.
- Echo Male Behavior Adjustment Unit: Unit A showers are visible. Unit B toilets are visible. Dorm C the shower curtains are not adequate. The facility had created a protype shower panel in the first shower.
- South Block: Unit SA showers are visible on each level. Unit SB showers visible on each level and from the hallways. Unit SC toilets and showers are visible. Unit SD the toilets and showers are visible. Unit SE the showers and toilets are visible. Unit SF the toilets and showers are visible.
- (b) (7)(E) [redacted]

(h) This section is non-applicable. The facility is not a Family Residential Facility.

(i) The facility's SAAPI and Searches policies outlines if prison staff has concerns regarding the gender of the detainee, they shall notify their supervisor. The supervisor shall coordinate with the medical authority to have the detainee evaluated by a licensed medical profession to determine the gender of the detainee. Only a licensed medical professional shall conduct body cavity searches. All random staff interviewed, except two, stated they had not conducted or been a witness to a search or physical examination to determine a detainee's gender. Of the two staff that indicated they had conducted a search for this purpose, one indicated they had strip searched the detainee and the other indicated the detainee was stripped down to the undergarments. Staff were aware of the policy and that detainees would be referred to medical for determination. A memo from the PSA Compliance Manager to file stated no visual body cavity searches had been conducted by medical or non-medical personnel during the audit year. There were no transgender or intersex detainees housed during the onsite audit to interview.

Does Not Meet: The facility does not attempt to determine gender through conversations with the detainee, by reviewing medical records, or if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. The facility policy and practice is not in compliance with the standard. The policy and practice is for the supervisor to coordinate with the medical authority to have the detainee evaluated by a licensed medical profession to determine

the gender of the detainee which is not part of a standard medical examination that all detainees undergo as part of intake or other processing procedure conducted by a medical practitioner. The facility needs to develop a practice to try to determine a detainee's gender through conversations with the detainee, reviewing medical records, or if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. The developed practice needs to be documented in policy and staff trained on the policy and procedure.

(j) The facility's SAAPI policy states searches of all types shall be conducted in accordance with prison procedures and training, including cross-gender searching requirements. The interviews with the Training Supervisor confirmed the training practices, as well as the review of the training lesson plan, "Contraband and Searches, Basic Training." The lesson plan is the PDOC's lesson plan utilized at their training academy and has one slide on transgender/intersex searches. A training computer print-out provided indicated that 469 security staff had completed the required training in January 2019. The facility has 665 staff who may have recurring contact with detainees and of that 494 are security staff. The documentation provided demonstrated that all staff have not been trained on searches; not even all the security staff. Training list of another class; Clothed and Unclothed Searches, which also addresses transgender searches was conducted in January 2019. Of that class, the records indicated that 632 staff attended the training. Random staff interviewed were knowledgeable on conducting searches and cross-gender searches. Staff was able to explain the process of conducting a cross-gender pat-down search by utilizing the back/blade of hand; only 4 of the 14 random staff interviewed acknowledged receiving training on transgender and intersex pat-down searches. In the review of six staff training records, only two staff attended the required training. Documentation was provided of eight ICE staff training files which documented training of searches through lesson plan "Cross-Gender, Transgender, and Intersex Searches."

Does Not Meet: Not all staff are trained on conducting cross-gender pat-down searches and transgender/intersex pat-down searches as documented through the training list provided, staff training files, and interviews with staff. All staff must be trained on conducting cross-gender pat-down searches and transgender/intersex pat-down searches. The facility needs to conduct training with staff that have not completed training for cross-gender pat-down searches and transgender/intersex pat-down searches. The training must be documented.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's SAAPI and Intake Processing policies state inmates/detainees will be provided orientation in writing in a language that they understand and/or, if unable to read, shall have the orientation presented to them verbally by the counselor. Policy also states staff will assist detainees that are deaf, visually impaired, and/or otherwise disabled or that have limited reading skills. The detainee shall be asked if he or she understands the orientation and shall acknowledge by signature that understanding. The facility has the Inmate/Detainee Handbook, ICE Zero Tolerance Poster, Reporting Memo, and ICE Sexual Abuse and Assault Awareness pamphlet available in English and Spanish. The ICE National Detainee Handbook is also available. The Warden indicated the facility utilizes staff interpreters, who are bilingual as a collateral duty, a TTY phone for the hearing impaired, a language line is available for use, and there is PREA information in the Inmate/Detainee Handbook in English and Spanish. The interview with the intake staff officer indicated detainees deaf or hard of hearing would have written materials available; detainees who have intellectual, psychiatric, or speech disabilities would have counselor, medical, and/or mental health staff assist with communication, and detainees who have limited reading skills staff would read the information and the video to provide the information. The two detainees interviewed that had low cognitive skills indicated that mental health staff provided the PREA information to them verbally and explained the information. The two detainees that could not read or write indicated they did not get PREA information at intake and can't read or understand the information on the housing unit bulletin boards. They ask other detainees if they have a question or need information. The Auditor interviewed intake officers on two different shifts, staff indicated there was no language/translator line. The phone in intake is available for the service but the system was not connected. Staff could not address how detainees that are deaf or hard of hearing would be provided the information. Eleven of the 14 random staff interviewed indicated they could provide PREA information to detainees through the Inmate/Detainee Handbook in English and Spanish for detainees hard of hearing or deaf; detainees that have intellectual, psychiatric, or speech disabilities would have the information explained to them verbally by going through the information slowly and at a level they would understand. There were no consistent answers on whether a PREA video is played for the detainees, about half the staff indicated no knowledge of a video and the other staff indicated a video is played at intake or in the housing unit.

Does Not Meet: The facility must ensure detainees with disabilities (including deaf or hard of hearing and cannot read) have an equal opportunity to participate in or benefit from all the agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The facility needs to develop procedures to provide deaf and detainees that cannot read PREA information in a manner they understand.

(b) The facility has the Inmate/Detainee Handbook, ICE Zero Tolerance Poster, Reporting Memo, and ICE Sexual Abuse and Assault Awareness Pamphlet available in English and Spanish. The ICE National Detainee Handbook is also available in seven languages (Simplified Chinese, Portuguese, Haitian, Hindi, English, Spanish, and Arabic). The Warden indicated the facility utilizes staff interpreters, a language line is available for use, and there is PREA information in the Inmate/Detainee Handbook in English and Spanish for those detainees with language barriers. The ICE PREA Zero Tolerance posters in English and Spanish, containing the name of the facility PSA Compliance Manager are posted on bulletin boards in the housing units. Also, posted are Sexual Abuse and Assault Awareness pamphlet and the Reporting Memo that includes reporting methods and emotional support contact information in English and Spanish. The ICE National Detainee Handbook includes a section (language identification guide) in the front of the handbook which outlines multiple languages to assist detainees who do not speak English or Spanish. During the audit, 11 interviews were conducted with limited English proficient detainees. The language line was utilized for detainees that spoke Spanish (10) and Mandarin (1). Only 5 of the 11 detainees interviewed stated they were provided information through a facility staff interpreter who is bilingual. Two detainees interviewed indicated the information was provided through other detainees used as interpreters (Mandarin and Spanish). The other four detainees stated they received the information on paper in a language they understood but staff did not explain. An Auditor during the tour met with four Chinese detainees who stated they were not provided a handbook in Chinese and a detainee interpreter was used at intake for confidential PREA questions. The intake staff indicated there is no translation/interpretation line to utilize and they will try to obtain a staff interpreter. If there is no staff interpreter available, they give the detainee the PREA paperwork and the Inmate/Detainee Handbook to read and have them sign for it even if it is not in a language they understand. If the detainee does not speak English or Spanish, they are given the information in English. Upon review of a sexual harassment investigation; the case was substantiated by the facility investigator against a staff member. However, the PREA Coordinator overturned the outcome noting a language barrier between the alleged staff member and the detainee during the alleged incident. The case being overturned on language barrier reinforces the non-compliance of 115.16. Four of the

random staff interviewed indicated that another detainee or inmate is utilized for interpretation services and two indicated that counselors utilize inmate interpreters if needed during the classification process. A random detainee that was interviewed stated he is used as an interpreter in classification and intake.

Does Not Meet: The facility must ensure detainees with limited English proficiency have an equal opportunity to participate in or benefit from all the agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The facility needs to provide PREA information in a language they understand. Staff are not utilizing and providing the ICE National Detainee Handbooks to detainees in a language they understand. The facility needs to provide limited English proficiency detainees an equal opportunity to participate in or benefit from all the agency's and facility's efforts to prevent, detect, and respond to sexual abuse. This should include interpretive services that enable effective, accurate, and impartial interpretation from intake, to postings in the housing units, provided education materials, and through the investigation process. Also, the facility needs to provide the ICE National Detainee Handbook to detainees in a language they understand.

(c) The facility has bilingual staff interpreters as a collateral duty. The facility has available to them the ERO Language Access Resource Center for interpretation services. Random staff interviewed was not aware of the available interpretation services. Two of the allegations were reported by limited English proficient detainees, in both cases staff interpreters were utilized for communication. Twelve of the random staff interviews indicated they would not utilize another detainee, a minor, the alleged abuser, a detainee witness, or a detainee who has a significant relationship to the alleged abuser for interpretation. Two staff indicated they would use another detainee. Through staff interviews and the absence of policy language, the Auditors could not determine if a detainee expresses a preference for another detainee to provide interpretation and the facility determines that such interpretation is appropriate and consistent with DHS policy on all three shifts, the detainee would be provided another detainee to interpret. The majority of detainees interviewed with limited English proficiency indicated they would communicate through another detainee that spoke English to tell an officer the need for the services.

Does Not Meet: The facility should allow a detainee who expresses a preference for another detainee to provide interpretation and the facility determines that such interpretation is appropriate and consistent with DHS policy on all three shifts, the detainee would be provided another detainee to interpret. Through the staff interviews and absence of policy language, the Auditors could not determine compliance. The facility needs to provide policy and procedure training with staff of when a detainee interpreter may be used and the availability of the language line services.

§115.17 – Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) Through review of the Personnel policy it was determined that the facility has established a system of conducting criminal background checks for new employees to ensure they do not hire or promote anyone who engaged in sexual abuse of another; been convicted of a sexually violent crime; and been convicted of a civil complaint regarding sexual abuse. The facility conducts the hiring and criminal background check process for the facility's employees, contractors, and volunteers. The policy states if the employee was a former correctional employee, all efforts shall be made to contact the previous facility(s) to determine if any substantiated allegations of abuse occurred or the employee resigned during a pending investigation of sexual abuse. The Human Resources Department personnel interview indicated this information is asked as part of the background check and the facility's Intelligence Office sends the Consent to Release Information for PREA Compliance to other institutions for information. The information can't be part of the application per the state's "Ban the Box" movement to eliminate discrimination during the hiring process. The Human Resources Department will receive a Certification Form from the Intelligence Office stating whether the applicant can be hired or not. If the facility is aware of an applicant or a staff for promotion has engaged in sexual abuse, they would not be hired or promoted by the interview with Human Resources personnel. The Volunteer Application states the volunteer must report to the YCP any criminal charges or accusations of sexual abuse, assault, or harassment, lodged against a volunteer by any person or entity. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a security shift supervisor or administration. The facility also has in place a system, DataWorksPlus, that is connected to the Pennsylvania State Police as a central repository for criminal arrests. This system provides notification if an employee is arrested. An Auditor randomly selected six facility employee files to review for the administrative adjudication check (the three questions) as part of the hiring process paperwork and the background check prior to hiring. The employee files were in compliance.

Through review of Executive Order 10450 Security Requirements for Government Employment and the Office of Personal Management Section Part 731 Suitability; and ICE Policy system Directive Title ICE Personnel Security and Suitability Program, it was determined that the agency has established a system of conducting criminal background checks for new ICE employees, contractors, and volunteers who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The interview with the Unit Chief of Personnel Security Unit (PSU) stated that all new employees are required to answer the three questions to ensure that they have not: engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt, or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse; and have not been civilly or administratively adjudicated to have engaged in the activity described within the standard. He indicated this is completed on the job application form and at the front of the interview. This is also reviewed as part of the background process. The standard addresses the utilization of this process in the promotional system, after reviewing the above policies, and during the SDDO interview, if any employee or contractor were involved in any misconduct of this nature, they would not be employed or contracted by DHS. Employees also have a continuing affirmative duty to report. The Unit Chief of Personnel stated staff are required to report any misconduct to their supervisor and to the Joint Intake Center (JIC) managed by ICE. This requirement is shared with staff in the PREA training. If the agency receives an arrest notification, this will be forwarded to OPR Investigation Unit and ICE Labor Relations.

Does Not Meet: The facility does not conduct background checks on contractors and volunteers. The facility's Personnel policy or staff interviewed could not address if the background check included whether the individual has been civilly or administratively adjudicated to have engaged 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 refuse. The facility must establish a system for conducting background checks on volunteers. The background check process for contractors and volunteers needs to review whether the individual has been civilly or administratively adjudicated to have engaged 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 refuse.

(c/d) The facility's Personnel policy requires a criminal background record check for all new hires to ensure the candidate is suitable for hiring. The facility's background check includes a criminal background check and a driver license records check. The results of the criminal record check will be reviewed by Prison Administration in conjunction with the County Human Resources Department and a decision will be made on eligibility for employment. The facility does not address the five-year requirement for background check for those facility staff who have contact with detainees. The Auditors randomly selected six employee files to review for the criminal background checks prior to hiring; all were completed prior to the hiring date however the updated background checks were not completed. The facility's policy does not address background checks for contractors. The Human Resource interview stated it is not a human resource function, it is conducted through the Intelligence Office. The interview with Human Resources stated contractors are cleared through background checks prior to entering the facility. The facility was unable to provide documentation of contractors' background checks.

Background checks of ICE employees are conducted through the PSU prior to an ICE employee or contractor being approved for hire or a volunteer approved to provide services. The agency conducts personnel security reviews on everyone that works for ICE by ensuring they are suitable for the position selected and they maintain a high level of character. During the background process the applicant, employee or contractor is asked questions directly related to sexual abuse in confinement settings enumerated in the standard, these questions are asked both in a written form and in person by the assigned investigator who conducts the interviews. The background check consists of a National Agency Check (NAC), education checks, residence checks, personal reference checks, and fingerprint check. The background coverage period is five years. The interview with the Contracting Officer's Representative (COR) and the Unit Chief of PSU stated that contractors are background checked by their company and asked the three questions during the application process. The agency also conducts background checks on the contractors. The background coverage period is determined by the risk of the position. Low or moderate risk positions have background checks completed every ten years. Positions that are considered high risk have background checks every five years. The background check for a contractor consists of National Agency Check (NAC), personal subject interview, employment checks, education checks, residence checks, credit checks, fingerprint check, and law enforcement check. The Auditor completed a request through PSU for background information on six ICE facility staff. The Auditor confirmed the background investigations for six ICE staff at the facility all were within the specified time limit of five years from the date of entry or the initiation of PREA.

Does Not Meet: The facility does not conduct five-year updated background checks on facility staff. The background check process for contractors could not be confirmed, documentation was not provided to the Auditors. The facility must conduct updated background checks on staff every five-years and background checks on contractors prior to assignment.

(e) The Personnel policy states if determined that an employee or applicant provided false information, it is grounds for immediate termination. The Human Resource staff interviewed confirmed that a person would not be hired, or a current employee would be terminated for falsifying information. The Human Resources interview indicated she was not aware of any applicants or staff terminated for false information or omissions.

(f) The Personnel policy states if the employee was a former correctional employee, all efforts shall be made to contact the previous facility(s) to determine if any substantiated allegations of abuse occurred or the employee resigned during a pending investigation of sexual abuse. The Human Resource personnel interview indicated this information is asked as part of the background check and the Intelligence Office sends the Consent to Release Information for PREA Compliance to other institutions for information. The Prison Security Office shall also, in accordance with the Human Resource Office, divulge this information if it exists to other correctional entities. The Human Resources staff indicated an employee does not have to consent to the information being shared with other institutions.

§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) The York County Prison was opened in 1997. The facility had numerous expansions: in 1992 added four housing blocks; in 1998 additional of a housing wing; in 2006 main medical and kitchen expansion; and in 2012 the addition of a work release center. There were no modifications to the existing facility since the DHS PREA incorporation date of December 26, 2016.. A memo to file and the interview with the Warden confirms no expansions or modifications have occurred.

(b) The facility had a video management system upgrade in June 2019. (b) (7)(E) [redacted] The facility also in April 2019 completed software upgrades and routine maintenance on the video system. (b) (7)(E) [redacted] The cameras have no sound capability and some of the newer cameras are able to pan, tilt, and zoom. (b) (7)(E) [redacted] All cameras are viewed at the central control center. Cameras operate on a 120-day recording system and stored on the facility's server system. The Warden and Facility Manager have access to the video footage. The last staffing analysis review identified additional cameras were needed in the kitchen area. This was identified through the Safety Commission, Security Review Committee, Cost Savings Committee, and staff from all departments as stated by the Warden. The Warden stated the additional cameras will provide viewing to enhance the safety and security of the facility and for investigation of allegations.

§115.21 – Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility SAAPI policy states all allegations of sexual harassment and assault will be investigated thoroughly in order to provide prompt health intervention to those involved, prosecution or disciplinary action against the perpetrators, while being sensitive to the needs of the victim. The policy states a preliminary investigation shall be conducted by prison administration, shift commander, or assigned supervisor immediately following an allegation. The Warden indicated the facility is responsible for administrative investigations and criminal investigations would be referred to the Pennsylvania State Police (PSP). The allegations are also reported to ICE, including to the AFOD and ICE staff at the facility for investigation and further action. If the investigation is not conducted by the PSP or ICE, the facility will complete the investigation by a specialized trained investigator. The PAQ indicates that four of the allegations were referred to outside law enforcement for investigation, PSP. Upon review of the investigation files for the audit period, only two were referred to PSP. The ICE OPR was notified of all the allegations. The ICE OPR did not

investigate an allegation per the PSA Compliance Manager. The SAAPI policy with the Notification of Sexual Contact Checklist provides a uniform evidence protocol for obtaining physical usable evidence. The PSA Compliance Manager did not know if the policy was developed in coordination with DHS, nor was there documentation that demonstrated the coordination. The facility does not hold juvenile detainees. The review of the investigation files with detail demonstrated that protocols were used for the collection of evidence.

Recommendation: The facility needs to review the policy with DHS and ensure coordination on any changes.

(b/d) The facility has attempted a memorandum of understanding (MOU) agreement with Young Women's Christian Association (YWCA) Community Outreach for rape crisis counseling. The facility provided emails to document the attempts started in April 2019. The SAAPI policy states outside counseling services may be approved for alleged or confirmed victims of sexual abuse. The mental health department shall coordinate with outside counseling services to ensure continuity of care/counseling. A mental health staff member is trained for trauma if needed. The PSA Compliance Manager stated the alleged victim is offered services when the allegation is reported. The services are provided to the detainee for support during the forensic exam and investigation process. If the detainee wants crisis counseling, the YWCA is contacted immediately stated the PSA Compliance Manager. The YWCA will come to the facility for crisis counseling private meetings or provide the counseling over the phone. The hotline number and victim advocacy services are provided to the detainees on the Reporting Memo on the housing units bulletin boards. Two detainees were interviewed that reported sexual abuse. The one detainee stated the abuse happened at another facility and stated someone helped him with his issues when he reported at this facility; he thinks the individual is from an agency outside the facility. The Auditor reviewed his healthcare file and noted that the detainee was seen by mental health seven days after reporting the victimization and there were no further case notes. The other detainee acknowledged seeing medical and mental health the same day the allegation was reported. He does not remember if community emotional support or counseling was offered. Upon review of his healthcare file, the Auditor could not determine if a referral was offered to the detainee. In the Auditor's review of the investigation files, there was no documentation demonstrating that emotional support or crisis counseling was offered or provided to the detainees. The Auditor attempted to contact the YWCA on four occasions to discuss the availability of services for the detainees. A representative was not able to be reached to discuss the partnership with the YCP.

Recommendation: The facility should consider offering alleged victims of sexual abuse community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling. The referral of services should be documented and maintained in the detainee file. The facility should also continue to attempt to achieve an MOU for victim advocacy services.

(c) All alleged victims of sexual assault who require a forensic exam are taken to York or Memorial Hospital emergency room for completion of the forensic exam and emergency medical healthcare per SAAPI policy and interview with the PSA Compliance Manager. The facility has attempted to obtain a MOU with the York Hospital for SANE services documented through emails between the facility and the hospital. The PSA Compliance Manager and Medical staff interviews stated the alleged victim would be taken to the local hospital for forensic exam and emergency medical healthcare. The services are available through the emergency department 24-hours a day 7 days a week. The Auditor interviewed a Coordinator from York Hospital after the onsite audit. The Coordinator confirmed the medical services including forensic exams are provided by the hospital. It was noted that if a SANE nurse is not on duty, a SANE nurse on-call would report. That a victim advocate would be provided at the hospital to the detainee during the forensic exam process. Although the PAQ noted two forensic exams were conducted, the PSA Compliance Manager indicated no forensic exams occurred this audit period. Upon review of the investigation files, the Auditors found no referrals to the local hospital for forensic exams. The PrimeCare Medical policy Response to Sexual Abuse states medical services and forensic exams are provided free of charge to the detainees. The one detainee interviewed indicated he received a bill for medical services and the facility paid the account. The PSA Compliance Manager indicated the medical statements are to be sent to the facility, however sometimes they are sent to the detainee directly. The facility pays the accounts for detainee medical services.

(e) The Warden indicated the facility is responsible for administrative investigations and criminal investigations would be referred to the PSP. All allegations are reported to the PSP and ICE, including to the AFOD and ICE staff at the facility for investigation and further action as stated by the PSA Compliance Manager and the Investigator. The facility does have a MOU with the PSP. There was no documentation that the facility has requested investigating agencies to follow the requirements of this standard when investigating an allegation.

Does Not Meet: There was no documentation that the facility has requested that investigating agencies follow the requirements of this standard. The facility must request that investigating agencies follow the requirements of the standard when conducting investigations.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/d) The facility SAAPI policy states all allegations of sexual harassment and assault will be investigated thoroughly in order to provide prompt health intervention to those involved, prosecution or disciplinary action against the perpetrators, while being sensitive to the needs of the victim. The policy states a preliminary investigation shall be conducted by prison administration, shift commander, or assigned supervisor immediately following an allegation. The Warden indicated the facility is responsible for administrative investigations and criminal investigations would be referred to the PSP. The Warden stated the York County Sheriff's Office does not have investigative roles per state statute. The District Attorney's Office can investigate and would refer the investigation to the PSP. The allegations are also reported to ICE, including to the AFOD and ICE staff at the facility for investigation and further action. If the investigation is not conducted by the PSP or ICE, the facility will complete the investigation by a specialized trained investigator. Upon review of the investigation files for the audit period, only two cases were referred to PSP. The PSA Compliance Manager/Investigator stated ICE did not complete any investigations. This could not be confirmed through the facility's investigation files. Through the review of the investigative files, notifications were made to ICE OPR of all the allegations; there were no references or documentation that ICE OPR conducted an investigation on any of the allegations. During the audit period, investigations were completed on nine allegations and were closed; two allegations were open and still under investigation. The allegations were referred immediately for investigation as documented in the investigation files.

(b) The SAAPI policy outlines the responsibility of the facility and other investigative agencies for investigations. The facility is responsible for administrative investigations and criminal investigations would be referred to PSP. The PSA Compliance Manager indicated that her role as the PSA Compliance Manager and Investigator is to assist as requested during an investigation by an outside investigative entity including answering requests for information, sharing of investigation reports, and complying with any requests. The Investigator stated she would stay in contact

with PSP for investigation updates. The policy also states the Deputy Warden of Centralized Services shall retain/track all allegations of abuse, including sexual assaults and sexual harassment for a period of at least five years. The reports and information will be maintained in an electronic format in a secure file. The PSA Compliance Manager indicated that all investigations are maintained for at least five years in hard copy, also stored electronically forever. An older case was reviewed to ensure compliance with the required time frame.

(c) On the facility's website, https://yorkcountypa.gov/courts-criminal-justice, states all allegations of sexual abuse and assault will be investigated thoroughly in order to provide prompt medical and administrative intervention to those involved. The website does not provide the investigative protocols or does the facility make the protocol available to the public in another method. ICE's protocol is posted on the agency's website; www.ice.gov/prea. The agency's website includes information on the agency's PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE National Detainee Handbook, ICE PREA Zero Tolerance poster, and Sexual Abuse and Assault Awareness pamphlet.

Does Not Meet: The facility does not make the investigative protocol available to the public through the website or another method. The facility must make the investigative protocol available to the public through the facility's website or another method.

(e/f) The facility's SAAPI policy requires that all allegations that involves an ICE detainee is reported immediately via the ICE email distribution list and the AFOD will be notified. If the incident is potentially criminal, when a staff member, contractor, and/or volunteer is alleged to be the perpetrator of sexual abuse, it will be referred to the PSP for investigation. The Investigation of Sexual Contact Checklist has a list of required notifications that includes that the ICE contact shall be notified promptly via the ICE email distribution. The Investigator stated all notifications are made to the ICE and PSP if criminal. The Warden indicated the Prison Board would be notified and the PDOC through the Extraordinary Occurrence Report. The review of the investigation files confirmed that notifications are made to the appropriate agency and facility staff.

§115.31 – Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b/c) The facility's SAAPI policy outlines that staff shall receive training about PREA and the SAAPI policy during the basic training academy PREA orientation session and as part of staff annual required training/orientation hours. The Deputy Warden of Centralized Services/designee is responsible for initial and yearly training of staff. The training lesson plan, PREA/SAAPI/Sexual Harassment from the PDOC addressed the zero tolerance policy; definitions and examples of prohibited and illegal sexual behavior; right of detainees and staff to be free from sexual abuse and from retaliation for reporting of prohibited and illegal sexual behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional signs of sexual abuse and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees; and requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. The policy states staff will be trained on how to prevent, detect, and report sexual abuse and harassment, including detainees with physical/mental disabilities and on the dynamics of sexual abuse/harassment in prison, the common reactions to the abuse, and how to avoid inappropriate relationships with detainees. The initial training occurs during the basic training academy, each staff member attends the academy pre-service training prior to being assigned to the facility. The training is also provided annually through the annual in-service training for all staff. Each staff employee is required to attend in-service annually. The Training Supervisor stated the staff receive PREA/SAAPI training annually and the training lesson plan covers all the requirements of the standard. Training is documented in the electronic system and a report can be created documenting who attended the training, Report of People Attending. Fourteen random staff interviewed indicated they receive training annually and updated information through emails and shift briefings. The other two staff indicated that had not received any PREA training. The PAQ indicates that 665 staff who may have recurring contact with detainees and of that 494 are security staff. A computer print-out documenting the 2018 PREA training indicated that 515 staff had completed the required training in 2018. Of the six facility employee training files reviewed by the Auditor; five of the employees received PREA training in 2018. Four of the staff had not completed training for 2016 and 2017. The employees have not completed annual training per the policy or even documented refresher training every two years. Four of the employees showed initial PREA training in 2015. The two ICE employees training files reviewed showed training in 2018 and 2019 with initial training in 2015. The ICE DDO interviewed indicated the training is provided electronically on the PALMS system.

Does Not Meet: The facility has not demonstrated that all employees have attended annual PREA training per policy or refresher training every two years by the standard. Nor can the facility document that all employees were trained within one year of December 2016. All employees must complete PREA training annually per policy or refresher information every two years per standard. The training must be documented.

§115.32 – Other training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b/c) The facility's SAAPI policy outlines that volunteers and contractors will receive training about PREA and the SAAPI policy during the PREA orientation session and as part of annual training/orientation hours. All contracted service providers, volunteers, and individuals who use prison resources shall receive information regarding sexual harassment or sexual contact with inmates/detainees during the orientation session and via pamphlet. The contractors and volunteers receive training through a PowerPoint presentation of the Prison Volunteer and Orientation Training Lesson Plan Sexual Abuse/Harassment Prevention Section. The training covers that announcements must be made upon entering a housing unit of the opposite gender, zero tolerance standard, reporting requirement to immediate supervisor or the Prison Administration, that all allegations will be investigated thoroughly, there is no consensual sexual activity with detainees, and sexual activity with a detainee will result in criminal charges. Contractors and volunteers shall also be made aware of the zero-tolerance standard and criminal penalties for sexual contact with a detainee. The Deputy Warden of Centralized Services/designee is responsible for initial and yearly training of contractors. The Staff Development and Training Manager is responsible for initial and yearly training of volunteers. The facility

has contracts for healthcare with PrimeCare Medical, commissary with Keefe Commissary, religious services with Good News Ministry, and education with LIU. Volunteers provide religious services, programming, and drug and alcohol intervention. The Training Supervisor stated all contractors and volunteers have been trained except for the Keefe contract staff. The Auditors observed the Keefe contract staff in the housing units having contact with detainees. When the Keefe staff was asked if they received PREA training, they indicated they had not received training. The facility could not provide the annual PREA training for the LIU education staff; the last training for education staff occurred in 2017. The healthcare staff receives PREA training, PREA: An Introduction and Overview, also through their agency electronic Relias system. The three contractors interviewed indicated all have received training prior to assignment through a classroom training with an instructor and a PowerPoint presentation. The two healthcare contractors stated they receive training annually through their agency. Contractors and volunteers must acknowledge receiving training through the signature on the Security Briefing Form. A sample of two contractors and two volunteers training files were provided to document compliance.

Does Not Meet: The facility does not provide training to all contract employees that have contact with detainees. The facility must provide training to all volunteers and contractors who have contact with detainees.

§115.33 – Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/f) The facility SAAPI policy states all inmates and detainees shall be notified during the intake process on how to report sexual harassment and abuse while incarcerated. This information shall also be included in the Inmate/Detainee Handbook. At intake, detainees are provided the YCP Inmate/Detainee Orientation to Preventing and Reporting Sexual Assault and Abuse in the Correctional Setting form (PREA form). This handout covers definitions of sexual abuse; zero tolerance; disciplinary charges for engaging in sexual abusive and assaultive behavior; reporting retaliation; consensual sex is prohibited; right to be safe; confidentiality; warning signs and red flags; reporting methods; can report anonymously; steps after reporting a sexual assault or attempted sexual assault; medical exam and healthcare services; investigation process; and emotional consequences of sexual abuse. The detainee must sign acknowledging the detainee has read and understood or a staff member read and explained to the detainee, and the detainee received a copy of the form. The form is available in English and Spanish. The detainee is also to receive the Inmate/Detainee Handbook, ICE National Detainee Handbook, and the ICE Sexual Abuse and Assault Awareness pamphlet as part of the intake orientation. The handbooks include information on sexual abuse prevention, sexual abuse reporting, sexual abuse treatment and counseling, and the grievance process. Staff indicated the PREA video is played during the orientation process. The Auditor observed two intakes during the on-site audit. The first intake observation was of a limited English proficient detainee (Spanish) on the first day of the on-site audit. The intake staff were not bilingual nor communicated with the detainee through a language line or staff interpreter. There is no interpretation line available to the intake staff. They provided the PREA handout in Spanish to the detainee and had him sign before he had a chance to read or ask questions. The detainee was provided the PREA form. He was not provided an Inmate/Detainee Handbook, ICE National Detainee Handbook, and the SAAPI pamphlet. The PREA video was not shown or being played in the detainee waiting area. The detainee then was escorted to medical. The second intake observation was an English-speaking detainee on the third day of the onsite audit. The detainee was provided the PREA handout and staff provided a quick explanation of what the form was and then had the detainee sign the form. The detainee was not provided the Inmate/Detainee Handbook, the ICE National Detainee Handbook, or the SAAPI brochure. The detainee was escorted to medical, as well as, the Auditor to observe the complete intake process. While in medical, the intake staff brought the Inmate/Detainee Handbook to the detainee. The Auditor asked the intake staff about the difference in the intakes observed; the staff indicated if there is time, they will provide a brief explanation. If a group of detainees arrive, they just hand them the PREA form because there is no time to explain or discuss due to the limited time to process the detainee and escort to medical. Of the detainees interviewed 13 (4 limited English, 2 with disabilities, and 7 English speaking) stated they did not receive the Inmate/Detainee Handbook, the ICE National Detainee Handbook, or the SAAPI brochure at intake and 20 (8 limited English, 2 with disabilities, and 11 English speaking) indicated they received the PREA informational materials. The majority of the detainees stated they had not received handbooks or the pamphlets. Only nine of the detainees stated they saw the video. During the audit period, 4,893 detainees were booked at the facility.

Does Not Meet (a)(f): The facility is not consistently providing detainees PREA orientation materials during the intake process. The facility is not providing the detainee the Inmate/Detainee Handbook, ICE National Detainee Handbook, and the ICE Sexual Abuse and Assault Awareness pamphlet. The video was not playing during the times the Auditor was observing intake. There is no consistent process of providing PREA orientation to detainees at intake. The facility needs to provide meaningful PREA orientation to all detainees at intake. The ICE National Detainee Handbook must be made available to the detainees or the information provided through an interpreter for limited English proficient detainees when an ICE National Detainee Handbook is not published in their language.

(b) The facility's SAAPI and Intake Processing policies states detainees will be provided orientation in writing in a language that they understand and/or, if unable to read, shall have the orientation presented to them verbally by the counselor. Policy also states staff will assist detainees that are deaf, visually impaired, and/or otherwise disabled or that have limited reading skills. The detainee shall be asked if he or she understands the orientation and shall acknowledge by signature that understanding. The facility has the Inmate/Detainee Handbook, ICE Zero Tolerance Poster, Reporting Memo, and ICE Sexual Abuse and Assault Awareness pamphlet available in English and Spanish. The ICE National Detainee Handbook is also available in seven languages (Simplified Chinese, Portuguese, Haitian, Hindi, English, Spanish, and Arabic). The Warden indicated the facility utilizes staff interpreters, a TTY phone for the hearing impaired, a language line is available for use, and there is PREA information in the Inmate/Detainee handbook in English and Spanish. The interview with the intake staff indicated detainees deaf or hard of hearing would have written materials available; detainees who have intellectual, psychiatric, or speech disabilities would have counselor, medical, and/or mental health staff assist with communication, and detainees who have limited reading skills staff would read the information and the video to provide the information. The two detainees interviewed that had low cognitive skills indicated that mental health staff provided the PREA information to them verbally and explained the information. The two detainees that could not read or write indicated they did not get PREA information at intake and can't read or understand the information on the housing unit bulletin boards. They ask other detainees if they have a question or need information. The Auditor interviewed the intake officers on two different shifts, staff indicated there was no language/translator line. A phone in intake is available for the service but the system was not connected. Staff could not address how detainees that are deaf or hard of hearing would be provided the information. An Auditor during the tour met with four Chinese detainees who stated they were not provided a handbook in Chinese and a detainee interpreter was used at intake for confidential PREA questions. The intake staff indicated there is no translation/interpretation line to utilize and they will try to obtain a staff interpreter. If there is no staff interpreter available, they give the

detainee the PREA form and the Inmate/Detainee Handbook to read and have them sign for it even if it is not in a language they understand. If the detainee does not speak English or Spanish, they are given the information in English.

Does Not Meet: The facility is not providing detainees that are limited English proficient, limited reading skills, and with disabilities PREA orientation in formats they can understand. Staff are not utilizing and providing the ICE National Detainee Handbooks to detainees in a language they understand. The facility must provide the detainee notification, orientation, and instruction in formats the detainee can understand.

(c) At intake, detainees are provided the YCP Inmate/Detainee Orientation to Preventing and Reporting Sexual Assault and Abuse in the Correctional Setting form (PREA form). The detainee must sign acknowledging the detainee has read and understood or a staff member read and explained to the detainee, and the detainee received a copy of the form. The detainees sign acknowledging the receipt of the handbooks and PREA pamphlet during the intake process. Eight detainee files were reviewed; 4 were detainees during the interview process stated they did not receive information at intake. All four of the detainees that stated they did not receive PREA orientation at intake, had the signed Inmate/Detainee Orientation to Preventing and Reporting Sexual Assault and Abuse in the Correctional Setting. The other four random detainee files reviewed; three had the signed Inmate/Detainee Orientation to Preventing and Reporting Sexual Assault and Abuse in the Correctional Setting form.

(d) The ICE PREA Zero Tolerance posters in English and Spanish, containing the name of the facility PSA Compliance Manager are posted on bulletin boards in the housing units. Also, posted are Sexual Abuse and Assault Awareness Pamphlet and the Reporting Memo that includes reporting methods and emotional support contact information in English and Spanish. The ICE National Detainee Handbook includes a section (language identification guide) in the front of the handbook which outlines multiple languages to assist detainees who do not speak English or Spanish.

(e) ICE Sexual Abuse and Assault Awareness Pamphlet is posted on bulletin boards within the facility. The bulletin boards are accessible to the detainees in dorm settings. In the cell housing blocks, the PREA information was posted on bulletin boards in the hallways which was not accessible to the detainees. The pamphlet is not distributed at intake.

Does Not Meet: The facility does not make the ICE Sexual Abuse and Assault Awareness pamphlet available to the detainee through accessible posting or distribution. The facility needs to have the ICE Sexual Abuse and Assault Awareness pamphlet available to the detainees or distribute it to each detainee. The celled housing blocks need to post the information within the housing block to allow detainees access to the PREA information.

§115.34 – Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's SAAPI policy states staff investigating allegations of sexual abuse or harassment have training to ensure compliance with PREA. The Training Supervisor interviewed that investigators do not receive the specialized training at the facility; they attend a PDOC training. The lesson plan utilized is PDOC PREA Training for Correctional Investigations. It is a 12-hour course. The PAQ states the facility has five investigators who have received training on sexual abuse investigations and cross agency coordination. There are five trained investigators; three received their training in June of 2018 and the other two in December 2018. The Auditors reviewed the nine closed investigation files; six of those were conducted by investigators with no training. The one investigator completed four investigators prior to training. The other two investigations were completed by staff with no training.

The ICE OPR was notified of all the allegations as documented in the investigation files. The PSA Compliance Manager/Investigator stated ICE did not complete any investigations. This could not be confirmed through the facility's investigation files. The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault; that covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the SharePoint to document compliance with the standard.

Does Not Meet: The facility conducts investigations with investigators that have not received specialized training for sexual abuse investigations and cross agency coordination. All facility investigators need to complete specialized training or only use the trained investigators to conduct the investigations.

(b)The facility has five specialized trained investigators who have completed the general PREA training and the required specialized training for investigators. Training is documented through class completion certificates. The specialty training was verified through the interview with the PSA Compliance Manager/Investigator also.

§115.35 – Specialized training: Medical and mental health care.

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

Notes:

(a/b) The facility has ICE Health Services Corps (IHSC) medical staff working at the facility. The Auditor interviewed the IHSC nurse and observed an initial medical screening. Their role is to conduct the initial medical screening at intake of a detainee and provide a medical release of detainees for deportation. They do not provide any medical treatment or mental health services and/or medication. If there is a health concern, a referral would be made to the facility healthcare. The IHSC staff receive specialized training through the IHSC Sexual Abuse and Prevention-PREA and IHSC Sexual Abuse and Assault Prevention and Intervention lesson plans. The RN stated training is received annually. Although the IHSC RN stated he received training annually, the Auditors focused on the training records of the facility's full-time medical and mental health staff that actually conduct the assessments, treatment, and would be the staff that responds to a sexual abuse incident.

(c) The facility has full-time contracted medical and mental health staff through PrimeCare Medical Inc. The PrimeCare Federal Sexual Abuse Regulations C,J-B-04 and YCP-B-04 policies states medical and mental health practitioners shall receive the training mandated for employees and sexual assault training is held annually for all medical staff. The healthcare staff receives basic PREA training, PREA: An Introduction and Overview, through the company's electronic Relias system. Training is also received through the NIC training modules of PREA: Your Role Responding to Sexual Abuse and PREA: Medical Healthcare for Sexual Assault Victims in a Confinement Setting. Documentation was also provided that demonstrated that PREA training occurs during monthly staff meetings. Training certificates of six healthcare staff were provided to document compliance with training. Not all healthcare staff have completed the specialized training as noted by medical staff interviewed, a confirmed number could not be provided. The facility is in compliance with the specialized training for medical and medical health staff. Healthcare staff do not conduct forensic exams. There is no documentation that the agency has reviewed and approved the facility's policy and procedures to ensure that facility medical staff is trained in procedures for examining and treating victims of sexual abuse.

Recommendation: The PrimeCare Medical Inc healthcare staff should all complete the specialized training through the NIC modules if this is the process for the medical specialized training.

Recommendation: The facility needs to have the healthcare policies reviewed and approved by the agency.

§115.41 – Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b/c/d) The screening process for the risk of victimization and abusiveness are outlined in the facility SAPPI and Intake Processing policies. The medical and intake counselors are to screen every newly admitted detainee upon reception for any history of sexual victimization and institutional sexual predatory behavior using the prison assessment tool, YCP Screening for Victimization and Abusiveness. The criteria used to assess for sexual victimization includes mental or physical ability; age; build; first incarceration; nonviolent history; prior history for sex offenses against an adult or child; sexual orientation LGBT; prior sexual victimization; and perception of vulnerability. The additional criteria of prior acts of sexual abuse and prior convictions for violent/sexual offenses are used to assess sexual abusiveness. The screening tool is a yes or no format. If there is a yes to one of the ten questions, the detainee is offered protective custody status. If answering yes to one of the questions regarding sexual abusiveness; a supervisor's review is required within one business day of assessment. Upon entering the facility, the detainee is held in a waiting area next to the intake processing desk until intake processing is completed. Two detainees can be processed at the intake processing desk at a time. After intake processing into the facility, the detainee is escorted to IHSC for initial medical screening. IHSC does not ask the PREA risk screening questions, however, there are targeted questions regarding sexual victimization and abusiveness. The IHSC RN stated if one of the targeted questions is confirmed, further screening questions would be asked. After the IHSC screening, the detainee is escorted to the medical intake. At medical intake, a nurse conducts the medical intake which includes general healthcare vitals and medical screening questions that includes the PREA screening questions. This is conducted and maintained in the medical electronic file. The Auditor observed the process. The detainee followed through the intake and screening process, had no risk factors for victimization or abusiveness. The nurse stated if the detainee scored for victimization, the electronic system would create a task for mental health. The nurse would also call mental health to inform them and the treatment manager. The task will show up on the mental health task assignment. The Classification Supervisor and Intake Staff interviewed stated if a detainee is screened at high risk of sexual victimization or a potential sexual abuse victim, mental health and the treatment manager would be called for services. They also indicated that detainees are housed in the pre-classification block until the classification process. The policy outlines once a custody level is generated it shall be provided to security staff to move the detainee to a pre-classification housing unit until the classification interview is completed. The detainees may not be moved to general population housing until a custody level, medical clearance, classification interview, and supervisor review is completed. Although the facility does not consider pre-classification housing as general population, the detainees are housed with other detainees prior to the classification process and housing determination in dorms for days up to weeks.

The staff also stated if a detainee self identifies as LGBTI, having previously experienced sexual victimization, potential aggressor, and/or expresses physical safety concerns; the detainee would meet with classification, and the PSA Compliance Manager and the Deputy Warden would be notified. Other than offering protective custody to detainees that score a yes on the risk screening tool; there are no housing determinations made to separate potential victims from potential abusers until classification process is completed. The Inmate Classification System policy states that detainees shall be assigned a custody level within 12 hours of admission. This custody level is based on current charge or custody levels when provided via Form I-213 Record of Deportable/Inadmissible Alien. This custody level is based on security and does not take into consideration the PREA risk screening. The policy states classifications interviews should normally occur within four days. The Classification Supervisor noted this could be about 5-7 days or longer if a large group of detainees arrived. The detainees interviewed stated the classification process and housing in pre-classification housing is usually for 2-3 weeks. Of the eight detainee files reviewed, four detainees had classification; three were over a month from admission and the other one 7 days. The other four whose admissions were April 30, April 23, May 10, and unknown; their classifications had not been completed.

Does Not Meet (a): The facility does not keep detainees separate from general population until the classification process is completed and housed accordingly. The facility needs to create a process to classify the at-risk detainees for housing to ensure safety prior to being housed in pre-classification dorms or cells with other detainees or inmates.

Does Not Meet (b): The initial classification and housing assignment does not occur within 12 hours of admission. The facility is conducting a risk assessment through medical within the time frame. Detainees are then housed in the pre-classification block for days to weeks prior to classification and housing determination. The facility needs to complete the initial classification and housing assignment within 12 hours of admission.

(e) The Inmate Classification System policy states classification reviews and reassessments should occur 60 days after initial classification and then every ninety days. Classification review and reassessments should also occur for the following reasons: status change, disciplinary convictions, and supervisor direction. The reassessment is a security custody reassessment, it does not address the risk of victimization or abusiveness. When the Classification Supervisor was asked if the reassessment includes mental or physical ability; age; build; prior incarceration; nonviolent history; criminal history, and prior history for sex offenses against an adult or child; he indicated those questions except for criminal history are not asked; however, all types of questions are asked. The other questions indicated by the Classification Supervisor are not related to the requirement of the

standard and are security-based questions. The reassessment is conducted using the Initial Custody Assessment Scale. Upon the Auditor's review of the reassessment tool, the tool asks about prior convictions, age, psychological impairment, mental deficiency, and physical impairment. Of the eight detainees' files reviewed, three detainees were held for a timeframe (just over sixty days) that may require a reassessment. The facility still was within the 60-90-day timeframe to complete the reassessment. The average time in custody is 60 days and with classification not occurring until about 30 days after admission; few detainees would meet the need of reclassification based on the current process. Two files were reviewed of detainees that reported sexual abuse; the Initial Custody Assessment Scale was completed however there was no reference to the report of sexual abuse.

Does Not Meet: The facility does not utilize a reassessment tool that reassesses the detainee's risk of victimization and abusiveness. The Initial Custody Assessment Scale utilized for reassessments focus on the security risk of the detainee and does not reassess the detainee's risk of victimization and abusiveness. The facility needs to create a reassessment tool that addresses the factors for accessing risk of victimization and abusiveness or to utilize the YCP Screening for Victimization and Abusiveness also during the reassessment.

(f) Through staff interviews with the Classification Supervisor, PSA Compliance Manager, and the Intake Staff it was stated disciplining detainees for refusing to answer or not providing complete information in response to certain screening questions is prohibited. The PSA Compliance Manager stated if a detainee refuses to answer a question, staff is to note the detainee refused. The counselor would meet with the detainee to see if the information can be obtained. And the detainee would be asked again at the reassessment. The form is an electronic form and maintained in the detainees file. The Classification Supervisor and PSA Compliance Manager stated the detainee does not have to answer questions and can refuse. Information from Form I-213 Record of Deportable/Inadmissible Alien would be utilized for information as much as possible. The detainee would be housed in medical until a further review is completed. If not completed the day of arrival, it would occur the next day. There were no detainees disciplined for refusing to answer questions per the PSA Compliance Manager.

(g) Staff interviews with the PSA Compliance Manager and the Classification Supervisor confirmed appropriate controls have been implemented to ensure that sensitive information is not exploited by staff or other detainees. The records are maintained electronically in the Inmate Management System (IMS) and only staff with that level of access has accessibility to the information through a password and security code. The information can be shared with the treatment committee and security as needed. The Auditor observed the information in the IMS and the classification staff showed the controls needed to access the information. One random detainee interviewed stated he is used for interpretation services for detainees in the classification process. Detainees interviewed also acknowledged that other detainees were used for interpretation during the intake and classification process. Staff also acknowledged this is the practice when staff are not available to interpret. One counselor did acknowledge that he tries to use an interpretation program on the computer to communicate with a detainee that is limited English proficient.

Does Not Meet: The facility is not maintaining appropriate controls on information by the use of inmate/detainee interpreters during the classification process. The facility must establish a process to controls of sensitive information and not use inmate/detainees for interpretation services.

§115.42 – Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's Inmate Classification System policy addresses the assessment process and the use of the screening information to determine housing, recreation, voluntary work, and other activities to ensure the safety of the detainee. The policy outlines once a custody level is generated it shall be provided to security staff to move the detainee to a pre-classification housing unit until the classification interview is completed. The detainees may not be moved to general population housing until a custody level, medical clearance, classification interview, and supervisor review is completed. Recreation is conducted one housing unit at a time. The policy states all classifications levels are decided by the general makeup of the total population of the facility and new arrivals are generally classified by criminal history and current offenses when assessing available verifiable information. YCP shall assign detainees to the least restrictive housing unit consistent with facility safety and security. The PSA Compliance Manager stated assessments are based on one-on-one interviews with the detainee taking into consideration the scoring of risk of victimization and abusiveness. The counselor can override based on criminal history and observation. The Classification Supervisor reviews the classification and housing placements. The Auditors could not determine if the facility is utilizing the risk screening and classification process to make appropriate housing, recreation, and other activities to ensure the safety of the detainee. Through review of the detainee files, it appears the security custody level alone is used to determine housing placement. One investigation file reviewed by the Auditor; it was noted that in the investigation the abuser had prior substantiated claims of abuse prior to the incident; the abuser was housed in a dorm setting. The Warden when asked stated he was not aware of that situation. The Classification Supervisor could not provide details or an explanation for the dorm housing placement.

Does Not Meet: The facility and policy could not demonstrate that information from the risk assessment is used to make assignments to housing other than offering a potential victim protective custody. Housing assignments are based on security custody levels. The facility needs to utilize the risk screening and classification process to determine housing other than by security custody level. If the facility is making decisions based on the risk assessment; the facility needs to document such decisions for documentation of the process.

(b) The facility's LGBTI policy states lesbian, bisexual, gay, gender-non-conforming, transgender, and intersex detainees are subject to housing in accordance with the Inmate Classification System and will consider all the factors in the standard when determining classification of the LGBTI detainee. However, special care shall be given to protect LGBTI detainee. The LGBTI detainees will be offered protective custody status upon admission to the facility; if the detainee refuses it shall be documented. The detainee may be placed on Temporary Secure Protective Custody (TSPC) until the Classification Committee can review the detainee for appropriate housing. The Committee considers the detainee's criminal history and past/present behavior; physical, mental, medical, and special needs; self-assessment of the detainee's safety need; privacy issues including showering and housing; and all records and assessment including medical and mental health. This screening and classification process were confirmed through interviews with the PSA Compliance Manager, Intake Staff, and the Classification Supervisor. At the time of the on-site audit, there were no transgender or intersex detainees housed. The Auditor reviewed a transgender detainee file that was released. The file contained the risk assessment, notes regarding housing placement, and the reassessment of the detainee within the appropriate timeframe. The transgender detainee file reviewed scored the transgender for possible victimization, the detainee was offered protective custody and refused. The detainee's initial assessment was December 6 and protective custody was refused. On December 17th, he was classified by counselor and a reassessment completed on December 27th. The detainee was released on December 31st.

(c) Transgender and intersex detainees have the opportunity to shower separate from other detainees. The LGBTI policy states transgender and intersex detainees living in a general population or segregated setting will be allowed to shower separately from other inmates/detainees. The staff will ensure the shower area is free from the other detainees/inmates for approximately 15 minutes in accordance with the unit shower schedule to allow the transgender detainee to shower separately. The detainee is to make their request to shower separately. The Auditor asked the classification staff if they inform transgender/intersex detainees about the shower policy; they indicated they do not. Interview with the PSA Compliance noted the facility will accommodate the transgender/intersex detainee by a specialized shower area and a scheduled shower time. The majority of random staff interviewed were aware that transgender detainees would be given the opportunity to shower separately from other detainees/inmates.

Recommendation: The transgender/intersex detainees should be informed of the showering options upon intake in the facility. The facility should not rely on the detainee to request to shower separately if they are not aware it is possible.

§115.43 – Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility's SAAPI and Inmate Classification policies outlines the protective custody placement to protect a vulnerable detainee from potential abusers until alternative housing assignment is determined. Only a supervisor may assign and remove a detainee from administrative housing. The SAAPI policy states the alleged victim shall be offered TSPC. If the detainee refuses, the detainee should be monitored closely in general population. TSPC is used when the detainee can't be protected by other means. If the detainee is placed into TSPC, the Program Review Committee will review the placement in 72 hours and a formal hearing held within 5 days to determine appropriate housing. The Warden stated TSPC is used as a last resort after all other ways to protect the detainee are reviewed. First the facility would look at a dorm setting where staff provide direct supervision. The Warden also stated the TSPC assignment would not exceed 30 days unless there are extraordinary circumstances or the detainee requests. An Auditor reviewed a detainee file that was placed in protective custody on request. The detainee entered protective custody on March 9th and was moved back to general population on March 20th. The policy and procedures were not developed in consultation with ICE Field Office Director (FOD).

Recommendation: The facility needs to have the healthcare policies reviewed and approved by the agency.

Does Not Meet: The facility does not or did not share with the Auditors a policy that provides written procedures consistent with the subparts of the standard. The facility needs to develop written procedures or expand the SAAPI policy to address all the components of the standard and document the procedures in place.

(c) The facility does not or did not share with the Auditors a policy that addresses the standard. There was no detainee placed in segregated housing for risk of victimization or following a sexual abuse allegation to interview. Both detainees interviewed that reported sexual abuse stated they were not held in protective custody. The Warden indicated detainees would have the same privileges as general population when possible based on operational feasibility and security concerns. The Warden stated detainees would maintain all program, privileges, and services available to the general population detainees; unless warranted through a disciplinary case. If a restriction would occur, it would be based on a disciplinary case and would be documented through an incident report and disciplinary process.

(d) The SAAPI policy states the Program Review Committee will review the placement in 72 hours and a formal hearing held within 5 days to determine appropriate housing for the detainee. The placement shall only continue past the five days in extraordinary circumstances. The Inmate Classification policy states the Program Review Committee will review the placement within 72 hours and then every 7 days for the first sixty days and then once a month thereafter to monitor the well-being of the detainee and make recommendations for reclassification. The Warden stated the Program Review Committee will conduct weekly reviews with the goal to get the detainee out of protective custody as soon as possible. The Program Review Committee is comprised of custody supervisor, unit manager, classification manager, licensed psychologist, and nurse. An Auditor reviewed a detainee file that was placed in protective custody on request. The detainee entered protective custody on March 9th and was moved back to general population on March 20th. Reviews were conducted on March 12, March 13, and March 14.

Does Not Meet: The written policy does not meet the standard that reviews will be conducted for the first 30 days weekly and every 10 days thereafter. As mentioned in (a), the facility needs to develop written procedures or expand the SAAPI policy to address all the components of the standard and document the procedures in place.

(e) Written procedures do not address the notification to the ICE FOD no later than 72 hours after the initial placement of a detainee in protective custody on the basis of a vulnerability to sexual abuse or assault. The Warden indicated the FOD is notified at 30 days. The one detainee file reviewed, did have notification to the AFOD within 72 hours.

Does Not Meet: The written policy does not address the standard language. As mentioned in (a), the facility needs to develop written procedures or expand the SAAPI policy to address all the components of the standard and document the procedures in place.

§115.51 – Detainee reporting.

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

Notes:

(a) The facility has established procedures allowing for multiple internal and external ways for detainees to report sexual abuse, retaliation, staff neglect, and violations of responsibilities that may have contributed to such incidents. PREA reporting methods are shared with detainees at intake including through the facility's Inmate/Detainee Handbook, ICE Detainee Handbook, and PREA pamphlet Sexual Abuse and Assault Awareness. Reporting information is also available on the DHS/ICE PREA posters in English and Spanish, containing the name of the facility's PREA Compliance Manager posted throughout the facility, including on all bulletin boards in the housing units. The Auditors during the tour viewed information on reporting methods posted on the bulletin boards in the housing units. The SAAPI policy outlines detainees may report abuse through staff, family, friends, letters, request slips, grievances, to the District Attorney, notify ICE, call the OIG hotline, and call their consulate. The detainees may also

report anonymously. A detainee in a housing unit showed the Auditors the tablets available in the housing units that detainees may use to email staff and ICE staff including reporting an incident. During the formal detainee interviews the detainees acknowledged knowing how to report through the information received in the housing units, from other detainees telling them, information on tablet, and in the handbooks. They were able to identify reporting methods including telling a staff member, call the DHS OIG toll-free hotline, writing a grievance, and/or telling family or friend. Also, during the informal interviews with detainees while touring the facility, they indicated they knew the reporting process and felt comfortable reporting to a staff member. Of the nine closed investigations, the detainees reported allegations to staff (2), reported to medical (1), PREA hotline (1), grievance (1), ICE request slip (1), yelled for help (1), and two incidents were observed by block officers who reported. An Auditor tested the hotline during the tour calling #55. The call reached a Shift Commander at the Borough Community Corrections Management Operations Center; a community corrections facility. The Shift Commander would report back to the facility Captain. These reporting methods were demonstrated through review of policies and procedures, handbooks, posters throughout the facility, review of investigation files, and interviews with detainees and staff.

(b) Detainees may report outside the facility to an entity that is not part of the facility by calling the DHS OIG toll-free hotline, write a letter to DHS Joint Intake Center, or call #55 hotline (Borough Community Corrections Management Operations Center). The facility's reporting methods are provided through the Inmate/Detainee Handbook, ICE National Detainee Handbook, PREA pamphlet Sexual Abuse and Assault Awareness, and the DHS OIG PREA poster which provides a hotline and states calls can be made anonymously and confidentially. On the bulletin boards there is a Reporting Memo posted that provides reporting numbers, consulates numbers, and other organizations contact numbers. The PSA Compliance Manager indicated anonymous reports could be made through the phone system, by writing a kite to staff or medical, and by third party. Upon review of the investigation files, one allegation was reported outside the facility through the PREA hotline. The majority of the random detainees interviewed did not know they could report anonymously even though this information is shared in the handbooks, PREA pamphlet Sexual Abuse and Assault Awareness, and on the ICE poster.

(c) Staff indicated through interviews they were aware of the methods available to them to report sexual abuse allegations. Staff were also knowledgeable on the methods that detainees could report to staff and their responsibility in the process. Staff acknowledged through interviews that they would report immediately any allegation to a supervisor and document it through an incident report. The SAAPI policy outlines that any staff, contractor, and volunteer must report the incident to a supervisor immediately. Staff receiving reports of sexual abuse/harassment, whether verbally, in writing, anonymously, or from third parties shall promptly report and document the incident. The reporting requirements and process is provided to staff through training and policy. During the audit time frame, two allegations were reported to staff who reported it immediately as documented in the investigation files.

§115.52 – Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility's Inmate Compliant Review System (Grievance Procedures) and SAAPI policies and the Inmate/Detainee Handbook addresses the administrative procedure for detainee grievances regarding sexual abuse. The facility does not impose a time limit for the submission of a grievance regarding an allegation of sexual abuse. A detainee can file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or compliant by submitting an 801 Complaint Form to the Grievance Coordinator. The Grievance Coordinator stated there were no time limits for a grievance regarding an allegation of sexual abuse. The handbook states the detainee may file a formal grievance related to sexual abuse at any time. There is no time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. The Grievance Coordinator stated all grievances are reviewed upon receiving, if the grievance is PREA related, an alert would be made to the Unit Manager and Shift Commander who could conduct a review. Medical and mental health would also be notified in order to examine the detainee. The Grievance Coordinator stated the grievance would be assigned for investigation immediately through the PREA Coordinator. The majority of the random detainees interviewed knew a formal grievance regarding sexual abuse could be filed. The majority of the random staff interviewed indicated a grievance received by a detainee would be given to a supervisor or be placed in the grievance box at the control center. The staff are able to open the grievance and review prior to forwarding the grievance. The grievance officer picks up the grievances from the grievance box every morning during working days; policy states the Grievance Coordinator shall pick up grievances each morning by 9:00 am at the Central Control Desk.

Recommendation: The facility should consider placing grievance boxes within the housing units to allow detainees to submit grievances to the Grievance Coordinator without going through numerous staff hands. This would also ensure that a grievance regarding a staff would be submitted without the staff member becoming aware of the grievance or a staff member not forwarding the grievance.

(c) The facility's Inmate Compliant Review System (Grievance Procedures) policy and Inmate/Detainee Handbook provides written procedures for submitting emergency grievances. Emergency grievances include any immediate threat to a detainee's safety, welfare, or health including sexual abuse, and timeframes for handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. The handbook encourages detainees who have emergencies grievances to inform their housing unit officer who will notify the appropriate shift supervisor who can respond immediately. If a detainee chooses to file a formal emergency grievance, the Grievance Coordinator will act on it upon receipt by removing the detainee from the housing unit and threat. The PSA Compliance Manager would be notified to start the investigation process. The Grievance Coordinator stated that an outcome must be completed within five days. The Grievance Coordinator indicated there were one PREA related grievance within the audit time period although the PAQ indicated four. Upon review of the four, two were outside the audit period and one was not PREA related. The grievance within the audit period was received on October 22 and referred for investigation the same day.

(d) The facility's Inmate Compliant Review System (Grievance Procedures) policy states the Grievance Coordinator will deliver all grievances with medical issues directly to the Health Services Administrator (HSA) or designee within 24 hours of receipt or the next business day. The Grievance Coordinator stated that medical and mental health would be notified immediately. Staff will take grievances regarding an allegation of sexual abuse and medical emergencies to the immediate attention of proper medical staff for further assessment. The Grievance Coordinator indicated in the interview that first contact would be to the PSA Compliance Manager and Shift Commander; then medical would be contacted. The Inmate/Detainee Handbook indicates the detainee will be offered protection, receive a medical examination, and offered mental health counseling. The grievance filed was for sexual harassment of a detainee from a staff member; staff-on-detainee sexual harassment. The detainee was not interviewed as part of the audit, he had been released in December 2018. The review of the investigation file documented the

detainee was seen by medical and mental health seven days after the grievance was received. Random staff interviewed indicated that if they were aware the grievance was related to sexual abuse, they would notify their supervisor right away who would determine if medical needed to be contacted.

Recommendation: The facility policy states the Grievance Coordinator will deliver all grievances with medical issues directly to the Health Services Administrator (HSA) or designee within 24 hours of receipt or the next business day. The facility should update the facility's policy to reflect that facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment as stated in the standard language and demonstrated in the facility practice.

(e) The facility's Inmate Compliant Review System (Grievance Procedures) policy outlines that upon receipt of the grievance, the Grievance Coordinator will investigate the compliant and provide a form to all staff or other individuals mentioned in the grievance in order to report their involvement. The staff member must respond to the Grievance Coordinator within 48 hours. The Grievance Coordinator will complete a written summary with recommendations which will be forwarded to the Deputy Warden of Centralized Services with a copy to the complainant no later than ten working days after the receipt of the compliant. Although the policy states ten working days, the Grievance Coordinator stated grievances related to sexual abuse are responded to within five days. The policy states that appeals are to be replied to within 21 days by the Deputy Warden and Grievance Coordinator. There is a multi-level appeal process. A memo to file stated there were no appeals during the audit period. The one grievance was responded to within the ten-day timeframe to inform the detainee it was referred for investigation. The detainee was released prior to the outcome of the investigation on December 4th. The policy does not require that all grievances and decisions with respect to sexual abuse grievances be forwarded to the ICE FOD at the end of the grievance process. This practice could not be verified through grievance information provided to the Auditor; the grievance was a sexual harassment and not sexual abuse. The facility's definition of sexual abuse does not include sexual harassment; the DHS PREA standard includes sexual harassment within the definition of sexual abuse.

Does Not Meet: The facility's policy and practice of providing an outcome to the detainee within ten days is outside the standard requirement of five days. The facility does not forward grievances of sexual harassment to the ICE FOD as sexual harassment is not defined in their policy as sexual abuse. The facility must update the policy and practice to meet the timeframe of five days for a decision per the standard language. The facility should handle sexual harassment grievances the same as sexual abuse grievances; as the DHS PREA includes sexual harassment as part of the definition of sexual abuse. All grievances of sexual harassment and sexual abuse need to be forwarded to the ICE FOD.

(f) The facility's Inmate Compliant Review System (Grievance Procedures) policy and Inmate/Detainee Handbook indicates that detainees may obtain assistance in preparing a grievance including from another inmate/detainee, staff member, family members, or legal representatives. The majority of the random detainees interviewed were not aware they could request assistance; although this information is provided in the Inmate/Detainee Handbook. The majority of the random staff interviewed indicated they would contact a shift supervisor or counselor to provide assistance to the detainee. One staff member indicated another detainee could assist. The Grievance Coordinator indicated that staff would assist the detainee and if there was a language barrier, a language line would be utilized to assist.

§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) The facility's SAAPI policy states detainees who allege sexual abuse may have communication with victim advocacy and rape crisis counseling services. Professional rape crisis counselors and/or advocates may be approved as an official visitor, providing there are no security concerns. The facility has attempted a memorandum of understanding (MOU) agreement with YWCA Community Outreach for rape crisis counseling. The facility provided emails to document the attempts started in April 2019. The SAAPI policy also states outside counseling services may be approved for alleged or confirmed victims of sexual abuse. The mental health department shall coordinate with outside counseling services to ensure continuity of care/counseling. A mental health staff member is trained for trauma, if needed. The PSA Compliance Manager stated the alleged victim is offered services when the allegation is reported. The services are provided to the detainee for support during the forensic exam and investigation process. If the detainee wants crisis counseling, the YWCA is contacted immediately stated the PSA Compliance Manager. The YWCA will come to the facility for crisis counseling private meetings or provide the counseling over the phone. Two detainees were interviewed that reported sexual abuse. The one detainee stated the abuse happened at another facility and when reported at YCP someone helped him with his issues and he thinks the individual is from an agency outside the facility. He said he is seen about once a month and he requested more; now he is seen about every 15 days. The Auditor reviewed his healthcare file and noted that the detainee was seen by mental health seven days after reporting the victimization and there were no further case notes. The other detainee acknowledged seeing medical and mental health the same day the allegation was reported. He does not remember if community emotional support or counseling was offered. Upon review of his healthcare file, the Auditor could not determine if a referral was offered to the detainee. In the review of the investigation files, there was no documentation demonstrating that emotional support or crisis counseling was offered or provided to the detainees. The Auditor attempted to contact the YWCA on four occasions to discuss the availability of services for the detainees. A representative was not able to be reached to discuss the partnership with the YCP.

Recommendation: The facility should consider documenting when confidential support services, crisis intervention, and counseling is offered and/or utilized by the detainee to document that services have been offered, utilized, and/or refused.

(c/d) The facility provides detainees information about local and national organizations that can assist detainees who have been victims of sexual abuse. The hotline number and victim advocacy services are provided to the detainees on the Reporting Memo on the housing unit bulletin boards and on the multi-agency phone contact list which includes national organizations. The Reporting Memo lists YWCA of York as the agency available to provide assistance to detainees of sexual assault or abuse. The YWCA's address and two hotline numbers, one being toll free, are listed. If the detainee is seen by YWCA counselors or mental health, this contact is confidential as possible. Phone calls to the YWCA are recorded; when the phone is utilized, a message plays that states calls may be recorded. There is also a sign by the phones that states phones are recorded. A lieutenant also stated all calls are recorded. Half of the random detainees interviewed were aware of the information about organizations that could provide emotional support. They indicated the information is posted and available on the tablets. This half of the detainees interviewed also were aware that the phones were monitored and referenced the posting on the wall regarding phones calls are recorded. The Inmate/Detainee Handbook states the hotline for reporting is not recorded and reports of sexual abuse may be forwarded to

authorities. The ICE Sexual Abuse and Assault Awareness pamphlet states information concerning your identity and the facts of your report will be limited to only those who need to know. The PSA Compliance Manager stated phone calls are monitored; visits and mail sent is not.

Recommendation: The facility needs to update the Inmate/Detainee Handbook to reflect that the hotline number is recorded as the signs in the housing units state, the phone message states when the phone is utilized, and as staff interviewed stated.

§115.54 – Third-party reporting

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

Notes:

The third-party reporting information is posted publicly on the facility's website, https://yorkcountypa.gov/courts-criminal-justice. The website provides information regarding reporting sexual abuse. The site outlines a third party and detainees may report allegations to facility staff, formal or informal grievance, request slip, report to ICE Field Office, and report to DHS or ICE Headquarters. The YMCA third-party reporting line, DHS OIG Hotline, ICE Detention Reporting and Information hotline, JIC hotline, and the address for ICE OPR are listed. The SAAPI policy states staff shall receive third party reports and promptly report and document the report. The Inmate/Detainee Handbook also states the hotline is not recorded in compliance with the PREA standard for third-party reporting. An Auditor tested the hotline during the tour calling #55. The call reached a Shift Commander at the Borough Community Corrections Management Operations Center where a detainee could third-party report. The Auditor did not see postings in the visitation area where postings would educate outside individuals. There were no third-party reports this audit period.

Recommendation: The facility should consider posting the third-party reporting methods in the areas of the facility where outside visitors have access, i.e. visiting.

§115.61 – Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility's SAAPI policy states any county employee, visitor, contractor, volunteer, or individual who has business with the prison or uses prison resources who witnesses what appears to be the sexual abuse of a detainee or has knowledge of potential abuse must report the incident to a supervisor. The supervisor will make the appropriate notifications of the allegation to prison administration and ICE through the email distribution list. Reporting requirements are covered in the annual in-service training, basic academy, and shift briefings for all staff. Specialized and random staff interviews confirm that staff are knowledgeable in their reporting duties, the process of reporting, and to whom to report. Random staff interviewed indicated they would report immediately to their supervisor and the PSA Compliance Manager; and then write an incident report. The majority of the staff could not provide how they could report outside the chain of command; when prompted they still said they must report to their supervisor. The PSA Compliance Manager stated staff can report privately outside the chain of command by reporting to the PSA Compliance Manager and/or Deputy Warden; by contacting County Human Resources; and contacting the PSP. The policy and procedures were not reviewed and approved by ICE FOD.

Recommendation: The facility needs to have the facility's policy reviewed and approved by the agency and maintain documentation.

Does Not Meet: The facility's policy does not address the requirements for staff to report retaliation against detainees or staff who reported or participated in an investigation of sexual abuse and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The facility needs to refresh staff on the methods to report an incident or misconduct outside the chain of command. The facility must expand the policy to address the language of the standard and provide training to staff on the policy changes, their requirement to report, and how to report outside the chain of command.

(c) The facility's SAAPI policy states staff receiving reports of sexual abuse/harassment whether made verbally, in writing, anonymously, or from third party shall promptly document the incident and limit the disclosure of information to individuals on a need-to-know basis in order to make decisions concerning the detainee's welfare and for law enforcement/investigative purposes. Reporting requirements including confidentiality are covered in the annual in-service training, basic academy, and shift briefings for all staff. Random staff interviewed indicated information would only be shared with the supervisor and other staff on a need-to-know basis.

(d) The facility does not hold juvenile detainees. The Warden did indicate if an alleged victim is a vulnerable adult; all mandatory reporting laws would be followed, and a report would be made immediately to local law enforcement and the ICE Field Office. The PSA Compliance Manager was not aware of any state or local vulnerable person statute.

§115.62 – Protection duties.

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

Notes:

All random staff interviewed indicated they would take immediate action to protect the detainee by separating the detainee from the area and other detainees to a safe location. Then report the incident to the supervisor for further action and write an incident report. These responsibilities are covered in the annual in-service training, basic academy training, and shift briefings for all staff. The Warden stated the staff are required to separate the detainee from the potential perpetrator and notify the supervisor. The detainee would be provided a housing change, the Warden indicated it would be to a dorm housing unit (not the pre-classification dorm) until a reassessment was completed for reclassification, and offered protective custody. An investigation would be initiated. Through the review of investigation reports, it appeared that the alleged victims were removed from the area immediately to a safe location and an investigation was started.

§115.63 – Report to other confinement facilities.

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

Notes:

(a/b/c) The facility's SAAPI policy states any report of abuse or harassment from another institution shall be referred immediately to the PREA Coordinator and PSA Compliance Manager for investigation and response. If the report involves an ICE detainee, the AFOD shall be notified. The PSA Compliance Manager stated the PREA Coordinator or PSA Compliance Manager would contact the other facility's Warden and/or PSA Compliance Manager within a day. The Warden stated an investigation would be started immediately. There was one allegation reported at intake this audit period. The PSA Compliance Manager stated the allegation was reported immediately to ICE and ICE informed the facility that the incident was already under investigation. Since the allegation was being investigated, there was no contact made with the other facility. This detainee was interviewed, he indicated the facility staff reviewed his case with him and told him that his case was still pending; and he would receive the notice of the investigation outcome once completed. The detainee stated the York facility wanted him to sign a paper and he refused. In the investigation file reviewed by the Auditor, the detainee refused to sign the Notification form acknowledging the update on the case. This detainee is the one that wrote the Auditor prior to the onsite audit. The detainee file demonstrated the notification to ICE through email within 90 minutes of reported.

(d) The PSA Compliance Manager interview further indicated, if the facility was to receive notification from another facility of an allegation of sexual abuse that occurred at the facility, an investigation would immediately be initiated; and the detainee would be referred to medical and mental health. Notification would also be made to the ICE FOD. The Warden also stated that an investigation would be started. There were no instances during this audit period per the Warden, PSA Compliance Manager, and indicated on the PAQ.

§115.64 – Responder duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's SAAPI policy clearly specifies the detailed procedures for security and non-security staff when responding to an allegation of sexual abuse. The first security staff member to respond to the incident is required to separate the alleged victim and abuser; immediately notify the supervisor and remain on scene until relieved by responding staff; secure the crime scene and any potential evidence; and advise the alleged victim to take no action to destroy evidence; and escort the detainee to the medical department. Through interviews with random staff, it was demonstrated that staff were knowledgeable in the steps as a first responder: to separate the alleged victim and abuser; preserve and protect the crime scene; and request the alleged victim and alleged abuser to take no action to destroy evidence; and contact a supervisor. First responder responsibilities are covered in the annual in-service training, basic academy, and shift briefings for all staff. During the review of the investigation files, it documented that staff took the appropriate steps when notified of an allegation. Of the nine closed investigations, the detainees reported allegations to staff (2), reported to medical (1), PREA hotline (1), grievance (1), ICE request slip (1), and yelled for help (1), and two incidents were observed by block officers who reported. A staff first responder was interviewed, the staff member stated the involved detainees were separated, shift commander was notified, preserved evidence by securing the scene, and then the lieutenant took over the investigation. Of the one detainee that reported an allegation that occurred at the facility; he stated he was immediately separated and taken to medical and the alleged abuser was taken to another area. He was also seen in mental health the same day. He was not asked about preserving evidence; the allegation was sexual harassment.

Does Not Meet: The facility policy does not address that staff ensures the alleged abuser does not take any action that could destroy evidence. The facility policy needs to be expanded to include the language of the standard and educate staff on the changes.

(b) The facility's SAAPI policy also outlines that if the first responder is not a security staff member, the individual must report to a supervisor and advise the alleged victim not to take any actions that could destroy physical evidence. The random non-security staff interviewed indicated they would contact a security staff member immediately and request the detainee not to destroy any evidence. They also stated they would remain with the alleged victim until a security staff member arrived.

§115.65 – Coordinated response.

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

Notes:

(a/b) The facility has created a written institutional plan, SAAPI policy (pages 9-17) and the Investigation of Sexual Contact Checklist, to coordinate actions taken by the multidisciplinary team including first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The Investigation of Sexual Contact Checklist provided the steps to be taken for an incident. The form has an area to document the date and time of the action and what staff member completed the task. The Investigation of Sexual Contact Checklist is maintained in the investigation file. The Warden stated he would be the incident commander of the incident and remain informed of the progress. Staff are trained through SAAPI training, the training of first responders, and conducting drills. The Auditors reviewed the investigation files for the checklists; there was no consistency on the use of the checklist for allegations and whether it was fully completed.

Recommendation: The facility should ensure the consistent use of the Investigation of Sexual Contact Checklist for each allegation as directed by policy and the checklist should be completed fully.

(c/d) The Warden stated the facility will turn over all the reports including medical to another DHS facility upon transfer of the detainee. All the reports and medical files would also be provided to a non-DHS facility unless the victim requests information not be shared. There were no instances of transfers of victims who would require notification to another facility during this audit period per memo to file and the PAQ. The other detainees were deported or released.

Recommendation: The facility should consider expanding the policy to include written procedures for staff on the standard requirements.

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

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

Notes:

The facility's SAAPI policy states an accused staff member, contractor, visitor, volunteer, or individual who has business with or uses prison resources may be suspended pending investigation of the allegation, but at a minimum separated from the alleged victim pending the outcome of the investigation. The Warden or designee, on a case by case basis, will make this decision based on the preponderance of evidence available at the time of the compliant. A notification to the PSP for possible criminal prosecution will be made based on the outcome of the preliminary investigation conducted by the facility and as determined by the Warden or designee. The Warden stated a staff member would be placed on administrative leave for an allegation of sexual abuse until the investigation was completed. If the case was substantiated, the staff member would be terminated. He also stated a staff member would be separated from the detainee by transferring the staff member to another housing unit or moved to a non-contact detainee post if the allegation was sexual harassment until the investigation is completed. If substantiated, the employee would be disciplined which may be up to termination. A volunteer would not be allowed in the facility until the investigation was completed. The facility operates with a collective bargaining agreements; the Warden indicated these agreements do not restrict the facility from removing staff from contact with detainees or restricts the termination based on substantiated sexual abuse. The staff member would be processed through the formal employee disciplinary process. Also, noted by the Warden there were no instances where a staff member, volunteer or contractor was terminated for allegations of sexual abuse.

In one of the allegations against staff (sexual harassment), the Auditor reviewed the investigation file; the staff member was reassigned to another housing area during the investigation and thereby separated from the alleged victim. The investigator substantiated the case, however the PREA Coordinator overturned the outcome noting a language barrier between the detainee and staff member during the incident. The officer was released back to normal operations with no restrictions where to work. The Auditor has a concern regarding this case; the review was conducted only by the PREA Coordinator who overturned the substantiated outcome rather than review by an Incident Review Team or Warden. The Auditor discussed this case with the Warden and the Warden was not aware of the case being overturned. The case being overturned on language barrier reinforces the non-compliance of 115.16.

§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) The facility's SAAPI policy states retaliatory action against a detainee for reporting sexual harassment or for providing information during an investigation is prohibited. The review of the one grievance, retaliation monitoring notes, and investigation reports showed no retaliation occurring or reported at the facility. The PSA Compliance Manager stated there were no instances of retaliation during the audit period. The PSA Compliance Manager is responsible for monitoring retaliation of detainees and the Security Office PREA Lieutenant for staff stated the Warden. Retaliation monitoring is maintained on a spreadsheet that documents the 30-day reviews with notes if there is any concerns or changes in the detainee housing. The retaliation tracking sheet is maintained in the PSA Compliance Manager's office and not placed in the investigation files at completion. Examples of the retaliation tracking form was provided to the Auditor after the on-site audit to demonstrate compliance.

(b) The PSA Compliance Manager indicated if retaliation was occurring, the protective measures to protect the detainee would be offering protective custody, a housing change, conduct a housing review, and reclassification if warranted. The PSA Compliance Manager also stated any allegation involving a staff member, the staff member would be moved to a non-detainee post during the investigation for retaliation. The protective measures for staff would be a change of post and referral to emotional support services. The Warden stated the separation of the victim and alleged abuser would be the priority, then an investigation would be started. If the staff member was retaliating, the staff member would be placed on administrative leave during the investigation. If substantiated, discipline up to termination would be initiated. If an inmate or detainee, the inmate/detainee would be disciplined through the disciplinary process. The protective measures would be taken immediately and an investigation would be started. In the one case monitored that was reviewed by the Auditor; the detainee had a housing change as a protective measure. The one detainee that reported sexual abuse stated other detainees were making comments stating it was his fault because he is gay. The detainee shared this information with staff; and he noted he was moved to another housing unit. He stated he was okay where he is housed now.

(c) The PSA Compliance Manager stated monitoring for retaliation of detainees is completed through monthly reviews with the detainee. Grievances, supervision logs, and discipline would be reviewed and considered, as well as, comments of the detainee. The meetings are documented on the retaliation Tracking Log spreadsheet. The Warden and PSA Compliance Manager stated the monitoring would be for at least 90 days, in most cases the monitoring would continue indefinitely while the victim is at the facility. The PREA Lieutenant monitoring staff would monitor internal investigations, post changes, change in mood, and call offs for staff retaliation. The monitoring would occur during rounds and a formal tracking process is not utilized. The Warden indicated there was no instances of retaliation.

Recommendation: The facility should consider utilizing the Tracking Log for the monitoring of staff or create another method of documenting the staff monitoring.

§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) The facility's SAAPI policy states the alleged victim shall be offered TSPC. If the detainee refuses TSPC, the detainee should be monitored closely in general population. TSPC is used when the detainee can't be protected by other means. The facility's SAAPI and Inmate Classification policies outlines the protective custody placement to protect a vulnerable detainee from potential abusers until alternative housing assignment is determined. The Warden stated the detainee would be placed in the least restricted housing based on the comfortability of the detainee and providing separation from the alleged abuser. The detainee would only be placed in TSPC if the detainee requested or under other security and safety circumstances, if warranted. The Warden stated the detainee would be held no longer than necessary indicating the detainee would be housed no longer than 5 days or less; unless warranted for safety or the detainee requested. He also stated a review would be conducted within 24 hours. The policy states the Program Review Committee would review the placement within 24 hours. There was one detainee housed in TSPC for protection during this audit period. An Auditor reviewed the detainee file that was placed in protective custody on request. There was no 24-hour review conducted since the detainee requested the placement and a review of appropriate housing was completed prior to the detainee's placement. The detainee entered protective custody on March 9th and was moved back to general population on March 20th. The detainee placement was for 11 days; the timeframe exceeded the 5 day at the request of the detainee.

(c) The facility's SAAPI policy states the reclassification of detainees who were abused sexually or were perpetrators of sexual abuse shall occur prior to their release to general population. The Warden stated the Program Review Committee will conduct reviews with the goal to get the detainee out of protective custody as soon as possible. The Warden stated the reassessment would be completed by classification and would take into consideration the vulnerability of the detainee. The detainee file reviewed contained classification notes regarding the reassessment of the detainee to general population. The Program Review Committee agreed with the reassessment of moving the detainee back to general population.

(d) The Warden and PSA Manager indicated the ICE FOD would be notified when a detainee was placed in protective custody for 72 hours or more. The notification is made through an email. The one detainee filed reviewed, did have notification to the AFOD within 72 hours.

§115.71 – Criminal and administrative investigations.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a) The facility SAAPI policy states all allegations of sexual harassment and assault will be investigated thoroughly in order to provide prompt health intervention to those involved, prosecution or disciplinary action against the perpetrators, while being sensitive to the needs of the victim. The policy states a preliminary investigation shall be conducted by prison administration, shift commander, or assigned supervisor immediately following an allegation. The Warden indicated the facility is responsible for administrative investigations and criminal investigations would be referred to the PSP. The Investigator stated the facility has attempted to obtain investigation reports from PSP, however, PSP will only provide an outcome finding to the facility and does not provide a copy of the investigative report. The facility's SAAPI policy also states staff investigating allegations of sexual abuse or harassment have training to ensure compliance with PREA. The Investigator interviewed stated investigations are started as swiftly as possible and the investigation reports are objective as taught through training. Of the 11 allegations, 9 investigations were completed and closed; 2 were still under investigation. The allegations were referred immediately for investigation as documented in the investigation files. The investigation reports were not thorough, four were just emails with outcomes. The majority of the investigations were completed within a month. The Auditors reviewed the nine closed investigation files; six of those were conducted by investigators with no training. The one investigator completed four investigations prior to training. The other two investigations were completed by staff with no training.

Does Not Meet: The investigation reports were not thorough and conducted by specially trained, qualified investigators. The facility needs to complete thorough investigation reports and the investigations need to be completed by specialized trained investigators.

(b) An administrative investigation was completed on all allegations as documented through the review of the investigation files. The administrative investigation is started immediately, if the allegation appears to be criminal the facility will notify PSP for investigation. The facility continues the administrative investigation to completion. The Warden and Investigator stated the administrative investigations are usually completed prior to the PSP notifications. The Investigator stated facility administrators do not coordinate with other entities when conducting an administrative sexual abuse investigation.

Recommendation: The facility policy provided did not address the administrative investigation process. The facility should expand the policy to provide standard language in the policy that outlines the administrative investigation process including when an administrative investigation will be conducted; to review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate; and administrative investigations shall be conducted after consultation with the appropriate investigation office within DHS and the assigned criminal investigative entity.

(c) The standard requires the agency to develop written procedures for administrative investigations to include: preservation of direct and circumstantial evidence; interviewing alleged witnesses, victims and perpetrators; reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; assessment of the credibility of the alleged victim without regard to the individuals status as a detainee, staff, or employee and without requiring any detainee to submit to a polygraph; documentation of each investigation by written report which shall include a description of physical and testimonial evidence, the reason behind the credibility assessments, investigative facts and findings and retention of reports for as long as the abuser is detained or employed by the agency plus 5 years, such procedures shall establish the coordination and sequencing of the two types of investigations. The facility does not have written procedures for administrative investigations that address the provisions of the standard. Also, upon the Auditors review of the investigation files; the files demonstrated that the provisions of the standard are not met in the investigation reports. All investigation reports were not thorough; and four of the nine investigations were just emails with outcomes. The PSA Compliance Manager/Investigator stated the facility has started to write formal reports as of August 2018.

The Warden did indicate that investigators review during the investigative process to determine if staff followed procedures and conducted proper supervision as part of the investigation process. During the review of the investigation files, the Auditors could not determine if the investigators take staff action into consideration, since the reports were not detailed or thorough. The policy also states the Deputy Warden of Centralized Services shall retain/track all allegations of abuse, including sexual assaults and sexual harassment for a period of at least five years. The reports and information will be maintained in an electronic format in a secure file. The PSA Compliance Manager/Investigator indicated that all investigations are maintained for at least five years in hard copy, also stored electronically forever.

Does Not Meet: The facility does not have written procedures for administrative investigations which include the provisions of the standard. The facility needs to provide standard language in a policy that outlines the written procedures for administrative investigation provisions as outlined in the standard and documentation of an investigation report that meets the provisions of the standard.

(e) The Warden and PSA Compliance Manager/Investigator interviewed stated the investigations would continue until completed upon departure of the alleged abuser or victim from the employment or control of the facility. The Warden indicated they may ask for assistance from the PSP in investigations where a staff member resigned. ICE assistance may be necessary to make detainees available for interviews upon transfer or release. Three of the investigations were in progress at the release of the detainees; all the investigations were completed.

(f) The PSA Compliance Manager indicated that her role as the PSA Compliance Manager and Investigator is to assist as requested during an investigation by an outside investigative entity including answering requests for information, sharing of investigation reports, and complying with any requests. The Investigator and Warden stated she would stay in contact with PSP for investigation updates, as well as, the Commander of

Security who is the liaison between the facility and PSP. Of the four cases referred to PSP, the Investigator indicated she remained informed. The investigation files contained emails between the Investigator and PSP.

§115.72 – Evidentiary standard for administrative investigations.

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

Notes:

The Investigator stated the standard of proof for administrative investigations is a preponderance of evidence, 51%. This is supported through the facility's SAAPI policy that states preponderance of evidence shall be the standard used for any administrative action taken as a result of sexual abuse or harassment.

§115.73 – Reporting to detainees.

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

Notes:

The facility's SAAPI policy states the PSA Compliance Manger shall notify each victim in writing the outcome of a sexual abuse investigation and any responsive action taken. The detainee is notified whether the allegation was determined substantiated, unsubstantiated, or unfounded through a written notification by the PSA Compliance Manager utilizing the Notification form. The detainee must sign acknowledging the receipt of the notification as demonstrated in the files and stated by the Warden. Of the nine cases closed reviewed by the Auditors, notifications were made to five of the detainees within a day of closing the investigation; the other four notifications could not be made since the detainee was released prior to the investigation completion. A copy of the notification is maintained as part of the investigative file.

§115.76 – Disciplinary sanctions for staff.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility Employee Corrective Action outlines the disciplinary process for employees. The SAAPI policy states any staff member who sexually harasses a detainee shall be subject to discipline, revocation of security clearance, and/or criminal sanctions. The Personnel policy states any employee who violates general rules and regulations shall be subject to appropriate discipline including termination of employment. The Warden stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact detainee post until the investigation is completed. If the case was substantiated, the employee would have to go through the employee disciplinary process before termination. There was one allegation of sexual harassment by a staff member that was substantiated through investigation; however, the PREA Coordinator made the termination to overturn the outcome noting a language barrier between the staff member and detainee during the incident without a review by the Incident Review Team or discussion with the Warden. The officer was released back to normal operations with no restrictions where to work. The Auditor questioned the overturn of the outcome and the lack of any discipline of the staff member. The Auditor discussed this case with the Warden and the Warden was not aware of the case being overturned. It appears the disciplinary process was not utilized for this case. A memo to file stated there were no terminations, resignations, or other sanctions of a staff member. The agency has not reviewed and approved the policies and procedures regarding disciplinary or adverse actions for staff.

Does Not Meet: The facility policies does not indicate that if there is a substantiated allegation, staff removal from their position and federal service is the presumptive disciplinary sanction. The facility needs to expand the policy to include the standard provision language and have the facility's policy reviewed and approved by the agency and maintain documentation.

(c) The Warden stated any staff removals or resignations for violating sexual abuse which are potential criminal cases would be reported to PSP. The PSP would be called initially with the information and followed by an email. The Warden stated notifications would be also made to ICE. The information will be retained in the employee's human resource permanent file. A memo to file indicated there were no incidents during the audit period as also noted on the PAQ.

(d)A memo to file indicated there were no incidents during the audit period as also noted on the PAQ. The Warden stated contractors are the only licensed employees at the facility. The Warden stated notifications would be made to ICE. The standard is not addressed in policy that the facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies to the extent known. The PAQ also indicated the facility does not make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies to the extent known.

Recommendation: The facility should make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies to the extent known. The facility should create a written process and procedure of how notifications would be made to relevant licensing bodies by the facility.

§115.77 – Corrective action for contractors and volunteers.

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

Notes:

(a/b) The SAAPI policy states any staff member, contract employee, and volunteer, who sexually abuses or harasses a detainee shall be subject to discipline, revocation of security clearance, and/or criminal sanctions. The notification to PSP for possible criminal prosecution is based on the outcome of the investigation and as determined by the Warden or designee. The Warden stated that the contractors are the only licensed employees and it would be the company's responsibility to report to any licensing body. The PAQ also indicated the facility does not make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies to the extent known. The Warden stated notifications would be made to ICE. Also, noted by the Warden, memo to file, and the PAQ there were no instances where a volunteer or contractor was removed for allegations of sexual abuse.

Does Not Meet: The facility does not make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies to the extent known. The facility needs to develop a process and procedure of how notifications would be made to relevant licensing bodies by the facility and not rely on the contracting company to report the violation.

(c) The SAAPI policy states the Warden or designee, on a case-by -case basis will make this decision based on the preponderance of evidence available at the time of the compliant whether to prohibit further contact with detainees. The Warden indicated each case would be evaluated and determined if the volunteer or contractor clearance be revoked based on the severity of the violation or prohibit contact with detainees.

§115.78 – Disciplinary sanctions for detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's SAAPI and Inmate Disciplinary Sanction policies outlines the detainee disciplinary process. A detainee is subject to disciplinary sanctions when an administrative or criminal investigation findings substantiated the detainee engaged in sexual abuse. The detainee offenses through the disciplinary process is reviewed by the Institutional Disciplinary Committee. The Committee is a three-person panel assigned by the Warden and consists of a shift supervisor, treatment staff, and a correctional officer. The Inmate/Detainee Handbook also informs the detainee of the disciplinary process. The Warden stated the detainee discipline would be through the internal disciplinary process. If criminal in nature, the local law enforcement agency would be contacted, and case referred to them. One case for this audit period was substantiated for sexual harassment and the detainee abuser was processed through the disciplinary process.

(b) The facility's Inmate Disciplinary Sanction policy outlines the offense categories and sanctions. Engaging in sexual acts and making sexual proposals or threats or harassing comments are classified within the high offense category. The Warden stated the code infractions and sanctions are from the ICE standards; the sanctions are commensurate with the severity of the act. The Warden stated the hearing board must work within the sentencing guideline table. The abuser in the substantiated case was processed through the disciplinary process and received disciplinary sanctions of disciplinary segregation housing placement for 33 days. The Warden indicated in the interview that disciplinary sanctions could include restrictions, internal discipline sanctions, segregation housing, and referral for criminal charges if warranted.

(c) The facility's Inmate Disciplinary Sanction policy has progressive levels of review, appeals, procedures, and documentation of the process. The detainee can appeal the disciplinary sanction within five days of the decision. The detainee will receive a copy of the appeal response in writing. The Warden stated the detainee can also file a grievance. The Warden confirmed the disciplinary process has progressive levels of review and appeals and a written report will be maintained in the detainee file.

(d) The SAAPI policy outlines the mental health counselor (MHC) will receive a copy of the disciplinary report within two days. The MHC counselor will interview the detainee to determine if there was a clear power imbalance between the involved inmates/detainees and staff. The Warden stated the detainee would be reviewed by mental health to determine if the detainee was stable to proceed with the disciplinary process. The policy does not address if the disciplinary process considers whether the detainee's mental disabilities or mental illness contributed to the detainee's behavior when determining what type of sanction, if any, should be imposed. The facility's memo to file states language is currently being amended to construct a diversionary policy, in regard to, determining disciplinary sanctions for inmates/detainees who display mental health disabilities and/or illnesses. The facility had identified the policy did not address the standard.

Does Not Meet: The facility's policy or practice does not address if the disciplinary process considers whether the detainee's mental disabilities or mental illness contributed to the detainee's behavior when determining what type of sanction, if any, should be imposed. The facility needs to develop a process for mental health to determine whether the detainee's mental disabilities or mental illness contributed to the detainee's behavior when determining what type of sanction, if any, should be imposed and expand policy to include the procedure.

(e) The facility's SAAPI policy states a detainee who has sexual contact with a staff member shall not be disciplined, unless the staff member did not consent to the contact. In this case, disciplinary action and referral for criminal prosecution shall occur. The Warden confirmed that a detainee would not be disciplined for consensual contact with a staff member. There were no instances to review.

(f) The facility's SAAPI policy states all reports of sexual abuse or harassment must be made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even is the allegation is not substantiated. The Warden stated the detainee would be disciplined only if there was concrete evidence the detainee lied. There have been no detainees disciplined for falsely reported.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b/c) The facility's SAAPI policy states any detainee who has a history or is a potential victim of sexual abuse shall be referred to the mental health department and Classification Committee for appropriate classification. The nurse stated if the detainee scored for victimization during the risk/health screening, the electronic system would create a task for mental health. The nurse would also call mental health to inform them and the treatment manager. The task will show up on the mental health task assignment which is checked daily by mental health. The mental health staff interviewed said the detainee is seen quickly, most times immediately. The Intake Staff interviewed stated a referral would be made as soon as the information is known. Intake staff would call mental health to inform them.

The PSA Compliance Manager stated medical, mental health, or security staff do not track the detainees who reported a history of sexual assault. The records are maintained in each detainees' independent files. A detainee list could not be provided for the Auditors to review the process for medical and mental health referrals and assessments to review for compliance. The Auditor did review a detainee file based on the detainee disclosed he had prior victimization during a random interview. Upon review of the file, the detainee was seen by mental health within 7 days of intake and was not seen by medical after the initial medical screening. The mental health case notes did not reference the referral was based on victimization or had any notes related to the PREA referral. The Auditor could not determine compliance since there were no notes referencing the referral or assessment of the detainee for the PREA referral.

Does Not Meet: The facility could not demonstrate that detainees receive a medical evaluation within two days when a medical referral is initiated or a mental health evaluation no later than 72 hours after referral. The facility needs to develop a process to ensure medical and mental health evaluations are conducted within the appropriate time frames. Medical and mental health staff need to develop case notes

referencing that the detainee has been referred for PREA to provide documentation of the process and the detainee was actually seen for the PREA referral.

Recommendation: The facility should establish a process to maintain a list of the detainees that disclosed prior victimization. The list would be a cross check reference for staff to ensue all detainees are seen by mental health in the appropriate timeframes.

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

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

Notes:

(a/b) The facility's SAAPI policy outlines all alleged victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by medical and mental health practitioners. The alleged victim will be escorted to the medical department and will be monitored by medical until transported to the hospital or a medical evaluation is completed. The alleged victim will be examined by the facility medical staff immediately to ensure the absence of any injury requiring urgent treatment. If sexual contact is suspected and the alleged victim reports an allegation of vaginal/oral/anal penetration or physical injury; the detainee will be immediately transported to the York or Memorial Hospital Emergency Room. The Health Care staff interviewed stated healthcare is provided immediately and the detainee has unimpeded access to emergency medical treatment and crisis intervention services. The medical treatment would be free for the detainees per the Health Care staff interviewed. The PrimeCare Medical policy Response to Sexual Abuse states medical services and forensic exams are provided free of charge to the detainees. The Health Care staff stated that healthcare is available to all detainees and there would be no discrimination on whether the victim names the abuser or cooperates with the investigation. The Health Care staff stated emergency contraception and sexually transmitted infections prophylaxis is not provided at the facility; it would occur at the hospital and may be available at the York Community Case Association. Medical and mental services were provided to the alleged victims per the investigation file reviews. One healthcare file was reviewed of the detainee that was interviewed for reporting sexual abuse. The detainee was seen by medical and mental health immediately as confirmed through the detainee interview. All alleged victims were seen the same day of reporting the allegations as noted in the medical and investigation files reviewed. Another detainee healthcare file was reviewed; the detainee that wrote the auditors. The detainee complained he was not seen by mental health once reporting an allegation. The incident occurred at another facility and was reported again at intake into the YCP facility. The detainee was seen by mental health upon reporting at YCP and is still receiving services.

§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) The Medical and Mental Health Staff interviewed stated the alleged victims receive medical and mental health evaluations and treatment is provided if needed. There is no cost to the detainee. All alleged victims were seen the same day of reporting the allegations as noted in the medical and investigation files reviewed. Medical and mental services were provided to all the alleged victims from the four allegations this audit period.

(b) The Warden stated when a detainee is transferred, the detainees' records including medical would be provided to the facility. Heath care staff stated the information would be shared with the other facility to ensure the detainee continues with follow-up services. The healthcare staff stated that referrals for continued care following transfer to another facility would be completed by healthcare and release from care would be completed through the facility's case management and IHSC for detainees that are deported.

(c/d/e) The PrimeCare Medical policy Response to Sexual Abuse and facility's SAAPI policy outlines prophylactic treatment and follow-up for sexually transmitted or other communicable diseases will be offered to the victim as clinically indicated. The healthcare staff will strongly encourage the victim to be tested for HIV and viral hepatitis six to eight weeks following the sexual abuse. The treatment would continue through medical orders by the medical staff. Additional education, follow-up treatment, counseling, and testing are provided as needed. If the abuse involved a female detainee and there has been vaginal penetration, the detainee will be offered a pregnancy test at the time of the medical evaluation; and if negative, should be offered retesting approximately six weeks later. Detainees who have positive tests will receive counseling and have access to all pregnancy related services. There were no alleged female victims during this audit period to interview or complete a file review. Although the PAQ noted two forensic exams were conducted, the PSA Compliance Manager indicated no forensic exams occurred this audit period. Upon review of the investigation files, the Auditors found no referrals to the local hospital for forensic exams occurred. None of the alleged victims this audit period required prophylactic treatment or testing. The healthcare staff, during their interviews, indicated that the healthcare services are consistent with the community level of care and in most cases better than the community since the detainee has immediate access to services.

(f) The medical treatment would be free for the detainees per the Medical Staff interviewed. Medical stated that healthcare is available to all detainees and there would be no discrimination on whether the victim names the abuser or cooperates with the investigation. The one detainee interviewed indicated he received a bill for medical services. The PSA Compliance Manager indicated the medical statements are to be sent to the facility, however, sometimes they are sent to the detainee directly. The detainee did not have to pay the bill, the facility covers all medical costs for detainees. The PrimeCare Medical policy Response to Sexual Abuse states medical services and forensic exams are provided free of charge to the detainees.

(g) The PrimeCare Medical policy Response to Sexual Abuse Policy states if the victim identifies the abuser, the abuser must be offered a mental health evaluation by the psychologist, who will evaluate the need for treatment. This evaluation has to occur within 60 days of the facility learning that the abuse has occurred. The Auditor reviewed a file that demonstrated a mental health evaluation was conducted on an identified abuser from a substantiated case. The mental health evaluation was completed within the 60-day requirement. The treatment notes stated the abuser does not want to be seen and refuses any treatment services.

§115.86 – Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility's SAAPI policy states the Deputy Warden of Centralized Services in conjunction with other prison administrators shall review all reports of sexual assault/abuse and ensure that appropriate administrative follow-up is completed. The review is documented on the Sexual Abuse or Assault Incident Review- Plan of Action Form. The form reviews the incident details, notifications, criminal investigation details, administrative investigation details, group dynamics (including race, ethnicity, gender identity, lesbian, gay, bisexual, transgender; intersex identification, status, or perceived status; or gang affiliation), staffing, physical plant, incident response, and policy and practice. There is also a recommendation page that lists recommendations and the method of implementation. The form has signatures for the lead reviewer (usually the PSA Compliance Manager) and PREA Coordinator. The Warden stated sexual abuse incident reviews are conducted utilizing the checklist and all the factors are considered that are relevant for the case. The PSA Compliance Manager stated the initial review is completed by the PSA Compliance Manager and then the Deputy Warden of Centralized Services/PREA Compliance Manager. She also stated only one person is involved in the reviews, and that is the individual who signs the bottom of the Sexual Abuse or Assault Incident Review- Plan of Action Form. The Auditors reviewed the nine closed investigation files for incident reviews; three files did not have incident reviews, four were completed after the 30-day requirement (8 months, 2 months, 4 months, and 2 months), and two were completed within the 30-day requirement. The incident reviews were not conducted by a review team; one staff member made the review, either the PREA Coordinator or the PSA Compliance Manager. The forms were not completed fully and three were not signed off by a Lead reviewer, PREA Coordinator, or the PSA Compliance Manager; a determination of who completed the review was not possible. Two reports noted recommendations, but there was no documentation the recommendations were implemented, or recommendations were forwarded for action. The Auditors could not determine if the reports were forwarded to the agency's PSA Coordinator. The investigator substantiated a case of staff-on-detainee sexual harassment, however the PREA Coordinator overturned the outcome noting a language barrier between the detainee and staff member during the incident. The officer was released back to normal operations with no restrictions where to work. The incident review should have been conducted by the Incident Review Team. The Incident Review Team could have completed a thorough review that confirmed or overturned the decision. There may have been further recommendations regarding staff actions and staff training on communicating with a limited English proficient detainee.

Does Not Meet: The facility does not complete the reviews by a team, completes the review form completely to address all the components of review, and the reviews are not completed within 30 days or not at all. The facility needs to complete the incident reviews by a review team considering and documenting all components of the standard are reviewed within the 30-day requirement. The facility must forward the review to the agency's PSA Coordinator.

(c) The facility's SAAPI policy states the Deputy Warden of Centralized Services shall retain/track all allegations of abuse, including sexual assaults and harassment for a period of at least five years. A final report shall be provided to the FOD annually. The Warden and PSA Compliance Manager indicated the annual report is completed by the PREA Coordinator. The report is shared with the FOD and the Prison Board. The fiscal year 2018 report was forwarded to the FOD on January 1, 2018. The report provides a brief narrative of each allegation and the outcome of the investigation, recommendations, and corrective actions. Recommendations included adding more cameras, sending more supervisors to investigation training, and adding a PREA lieutenant. Based on discussions with the Warden and PSA Compliance Manager, all the recommendations were completed or in process. A PREA lieutenant was added to the Intelligence Office, (b) (7)(E) [redacted], and additional staff were sent for investigation training. Additional staff will be scheduled for investigation training.

§115.87 – Data collection.

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

Notes:

The facility's SAAPI policy states the Deputy Warden of Centralized Services shall retain/track all allegations of abuse, including sexual assaults and harassment for a period of at least five years. The dates, locations, names of victims and assailants and filing of the reports shall be securely maintained in chronological order. The reports and information will be maintained in an electronic format in a secure file. The Warden and PSA Compliance Manager confirmed this practice.

§115.201 – Scope of audits.

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

Notes:

(d) During the audit, the facility and agency provided the Auditors full access to all areas of the facility and the Auditors were able to observe practices and tour the facility.

(e) Prior to the audit, during the audit, and after the on-site audit, the agency and facility provided the Auditor requested documents. Policies and documentation were made available through the ICE ERAU SharePoint.

(i) Private interview space was provided to the Auditors for conducting staff and detainee interviews. Staff interviews were held in administrative offices in the administration section of the facility. The detainee interviews were held in private offices located within a secure section of the facility.

(j) Posted signs advised detainees they could send confidential information or correspondence to the Auditor. The Auditor did receive a detainee correspondence prior to the on-site audit and another correspondence after the onsite audit. The second correspondence was forwarded to the ERAU Team Lead for action. The Auditor was informed the correspondence was not from a detainee; it was from an inmate. The correspondence was shared with the AFOD for review and action.

Based on the above information, the agency/facility meets the Standard 115.201 Scope of Audits.

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.

Barbara King August 27, 2019
Auditor's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Barbara A. King	**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:	Philadelphia Field Office
Field Office Director:	Simona Flores
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	114 N. 8th Street, Philadelphia, Pennsylvania 19107
Mailing address: *(if different from above)*	N/A

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	York County Prison		
Physical address:	3400 Concord Road, Pennsylvania 17402		
Mailing address: *(if different from above)*	N/A		
Telephone number:	717-840-7580		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	717-840-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Population Manager/PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	717-840-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) audit of the York County Prison (YCP) was conducted on May 21-23, 2019, by lead Auditor Barbara King and team member (b) (6), (b) (7)(C) both certified Department of Justice (DOJ) and Department of Homeland Security (DHS) PREA Auditors employed through Creative Corrections, LLC. York County Prison is a county jail facility operated by York County and overseen by the Prison Board of Inspections. The Prison Board of Inspections consists of the Sheriff, District Attorney, County Commissioners, County Controller, and a Judge. The facility has a contract with U.S. Immigration and Customs Enforcement (ICE) for the housing of both adult male and female detainees. The facility's DHS PREA incorporation date is December 23, 2016. The purpose of the audit was to determine compliance with the DHS PREA Standards for a Subpart A facility. This was the first DHS ICE PREA audit of the facility. The audit period covered the previous 12 months from May 21, 2018, through May 23, 2019. This portion of the report covers the Auditor's final determinations on those standards initially deemed non-compliant and placed into a Correction Action Plan (CAP) period.

The facility initially had 19 standards that Met, 21 standards that Did Not Meet, and 1 standard that was Non-Applicable.

Standards that Did Not Meet:

115.15 Limited to Cross-Gender Viewing and Searches
115.16 Accommodating Detainees with Disabilities and Detainees Who Are Limited English Proficient
115.17 Hiring and Promotion Decisions
115.21 Evidence Protocols and Forensic Medical Examinations
115.22 Policies to Ensure Investigation of Allegations and Appropriate Agency Oversight
115.31 Staff Training
115.32 Other Training
115.33 Detainee Training
115.34 Specialized Training: Investigations
115.41 Assessment for Risk of Victimization and Abusiveness
115.42 Use of Assessment Information
115.43 Protective Custody
115.52 Grievances
115.61 Staff and Agency Reporting Duties
115.64 Responder Duties
115.71 Criminal and Administrative Investigations
115.76 Disciplinary Sanctions for Staff
115.77 Corrective Action for Contractors and Volunteers
115.78 Disciplinary Sanctions for Detainees
115.81 Medical and Mental Health Assessments, History of Sexual Abuse
115.86 Sexual Abuse Incident Reviews

The agency provided the Auditor the CAP on September 9, 2019, which was reviewed by the Auditor and responses provided to the proposed compliance actions. The 180-day CAP process ending date was February 24, 2020. The facility submitted documentation for the corrective action process on October 23, 2019, through February 24, 2020. The facility's policy Sexual Abuse, Assault, Prevention, and Intervention (SAAPI) language was updated to reflect the compliance changes made during the CAP process in October 2019. The Field Officer Director's (FOD) review and approval was obtained on November 26, 2019, and the policy's effective date was February 20, 2020. The facility started updated training on the policy updates during annual PREA training in November 2019 within the CAP period and completed the training updates during an August 2020 PREA Booster Training. The Auditor reviewed and accepted training documentation from August 2020, which occurred outside the CAP period, due to the facility being unable to conduct the PREA refresher training due to COVID protocols in place during the CAP period. In a review of the submitted documentation to demonstrate compliance with the deficient standards, the Auditor determined partial compliance with 20 of the standards. At the end of the CAP period, standard 115.81 remained open due to lack of evidentiary documentation, specifically a file supporting a detainee who reported prior sexual victimization or abusiveness during the risk assessment was referred to medical or mental health. In an effort to show the facility's process and practice, YCP provided an example of an inmate who was referred to mental health. This referral process for a detainee was then reviewed on-site. A CAP reinspection on-site visit was conducted to verify full compliance with all the standards. Full compliance with each standard was contingent upon staff and detainee interviews, additional on-site documentation review, and facility observations during the CAP reinspection on-site visit.

The Auditor conducted the CAP reinspection on-site visit on April 6-8, 2021. The re-inspection visit was postponed due to the COVID-19 health pandemic. The reinspection on-site visit was rescheduled once the facility determined the environment was safe for the Auditor, ICE staff, facility staff, and the detainees. At the time of the on-site visit, the facility's total population was 1,300 and the detainee population was 260; furthermore, the facility had ten housing units under quarantine for COVID precautions.

Before the start of the CAP reinspection on-site visit, the Auditor met with agency and facility staff. The Team Lead opened the entry briefing at 8:15 am on the first day of the on-site visit. In attendance were:

- (b) (6), (b) (7)(C) Inspections and Compliance Specialist (ICS), ICE/Office of Professional Responsibility (OPR)/ External Review and Analysis Unit (ERAU)

- Clair Doll — Warden
- (b) (6), (b) (7)(C) — Deputy Warden of Security
- (b) (6), (b) (7)(C) — Population Manager/ Prevention of Sexual Assault (PSA) Compliance Manager
- (b) (6), (b) (7)(C) — Correctional Officer
- (b) (6), (b) (7)(C) — Correctional Officer
- (b) (6), (b) (7)(C) — Commander, PREA Lieutenant
- (b) (6), (b) (7)(C) — Supervisory Detention and Deportation Officer (SDDO), ICE, Enforcement and Removal Operations (ERO)
- (b) (6), (b) (7)(C) — Health Services Administrator (HSA), Prime Care Medical
- Barbara King — Program Manager/PREA Auditor, Creative Corrections, LLC.

Brief introductions were made and the detailed schedule for the visit was covered. The Lead Auditor provided an overview of the CAP reinspection on-site visit process and methodology used to demonstrate PREA compliance. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to ascertain whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, additional on-site documentation review, and conducting both staff and detainee interviews.

A facility tour was completed by the Auditor with key staff. All housing units were toured (except the 10 housing units under quarantine), as well as, program areas, service areas, food service, control center, admissions/intake, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or provided services were observed by the Auditor. During the tour, the Auditor made visual observations of the program/service areas and housing units including bathrooms, officers post sight lines, and camera locations. Sight lines and potential cross-gender viewing areas identified during the previous site visit were closely examined for compliance. The Auditor spoke to random staff and detainees regarding PREA education and facility practices during the tour. Review of the housing unit logbooks was conducted to verify PREA rounds for security staff and supervisors. Interviews were conducted with 11 detainees, 5 security staff, and 3 contractors. Key facility staff involved during the on-site audit included the Warden, PSA Compliance Manager, Deputy Warden of Security, Commander/PREA Lieutenant, and two correctional officers.

There were 14 sexual abuse allegations reported during the CAP by the facility and only 10 allegations reflected on the ICE PREA Allegation spreadsheet. The four cases were reconciled; three cases were allegations reported at the facility that occurred at another facility in which ICE reports in the database of the facility the incident occurred, and the other allegation the facility reported to ICE on January 17, 2020 and this notification was documented on the Sexual Abuse or Assault Incident Review - Plan of Action Report in the investigative file. There is no further documentation to understand where the breakdown in notifications occurred. The 14 sexual abuse allegations reported by the facility were: 7 detainee-on-detainee (4 sexual harassment, 3 sexual abuse), 3 staff-on-detainee (1 sexual harassment, 2 sexual abuse), 1 contractor-on-detainee (sexual abuse), and 3 allegations reported that occurred at another facility. The staff-on-detainee allegations investigative outcomes were unfounded for the sexual harassment, one abuse allegation was found unsubstantiated, and the other was still open. The investigative outcome of the contractor-on-detainee allegation of sexual abuse was unfounded. The investigative outcomes of the four sexual harassment detainee-on-detainee allegations were one unfounded, two unsubstantiated, and one substantiated. The investigative outcomes of the three sexual abuse detainee-on-detainee allegations were one unsubstantiated and two substantiated. The Pennsylvania State Police was notified on all criminal cases and the ICE ERO was notified as documented through the investigative files. A thorough review of 10 investigative cases were reviewed by the Auditor.

An exit briefing was conducted by the Team Lead and Auditor at the completion of the on-site audit. The following participants were in attendance:

- (b) (6), (b) (7)(C) — ICS, ICE/OPR/ERAU
- Clair Doll — Warden
- (b) (6), (b) (7)(C) — Deputy Warden of Security
- (b) (6), (b) (7)(C) — Population Manager/ PSA Compliance Manager
- (b) (6), (b) (7)(C) — Commander, PREA Lieutenant
- (b) (6), (b) (7)(C) — SDDO, ICE
- (b) (6), (b) (7)(C) — HSA, Prime Care Medical
- (b) (6), (b) (7)(C) — Director of Nursing
- (b) (6), (b) (7)(C) — Administrator of Behavioral Services
- Barbara King — Program Manager/PREA Auditor, Creative Corrections, LLC.

While the Auditor could not provide the facility a final finding per standard, the Auditor did provide a preliminary status of the findings with 18 standards met compliance and 2 standards were still under review. Recommendations were shared with the facility that will be addressed under the appropriate standard in the narrative section.

The Auditor shared with those in attendance the appreciation of the hospitality received and for the professionalism provided by all staff during the visit. The Auditor observed interactions between staff and detainees in a positive manner throughout the on-site audit. The Auditors shared with the Warden and the facility's staff the feedback received from the detainee population regarding the facility's operations, the positive interviews with staff, and the professionalism demonstrated by staff during the audit. The Auditor thanked the York County Prison, Warden Doll, and all the facility staff for their work and commitment to the DHS Prison Rape Elimination Act.

The following standards remain non-complaint:

115.16 Accommodating Detainees with Disabilities and Detainees Who Are Limited English Proficient
115.33 Detainee Training
115.41 Assessment for Risk of Victimization and Abusiveness
115.42 Use of Assessment Information
115.81 Medical and Mental Health Assessments, History of Sexual Abuse

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. 15 - Limits to cross-gender viewing and searches

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

Notes:

(b)(d): The facility's SAAPI and Searches policies state staff shall conduct pat-down searches of the same gender inmates/detainees, except in exigent circumstances. In the event a cross-gender pat-down search is required; the staff member shall document the search on an officer's daily report. This report shall be forwarded to the Shift Commander for review and action. Random staff interviewed stated it is common for female staff to pat-down male detainees going to recreation, while working a male housing unit, and during admissions. The Auditors observed female staff conducting pat-down searches on male detainees going to recreation. The facility did not document cross-gender pat-down searches prior to April 9, 2019, stated in the memo to file. The PAQ states not all cross-gender pat-down searches are documented. The memo also stated that security staff were informed of the updated policy that pat-down searches are to be conducted by the same gender through staff email and a memo attached to a paycheck. There was no documentation for the routine cross-gender pat-down searches conducted by female staff on male detainees.

Does Not Meet(b)(d): The facility has a common practice of allowing female staff to conduct cross-gender pat-down searches on male detainees when going to recreation and when providing supervision in a male housing unit. These cross-gender pat-down searches are not documented. The facility needs to follow the facility policy and standard and eliminate the common practice of cross-gender pat-down searches of male detainees by female staff except in exigent circumstances. When cross-gender pat-down searches occur, the searches are to be documented.

Corrective Action Taken (b)(d): The facility provided updated policy language in September 2019 that specifically addresses pat-searches by female staff; the policy now limits female officer pat-searches of male detainees to exigent circumstances only. The policy 2.1 Sexual Abuse, Assault, Prevention, and Intervention states, "Pat-down searches and strip searches of detainees and inmates shall be conducted by the same gender staff member. Opposite gender strip searches and pat-down searches are prohibited, except in exigent circumstances. All pat-down searches of the opposite gender conducted under exigent circumstances shall be documented on an officer's daily report. All reports must be forwarded to the Shift Commander no later than the end of shift and shall be tracked by Operational Support Services. Strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted, except in exigent circumstances." A PREA Booster training was conducted in August 2020 for all staff that included the changes in the policy for cross-gender searches. The Auditor reviewed eight staff training files and a training roster that verified the training. The security staff interviewed stated that pat-down searches are conducted by the same gender staff and the policy had changed to reflect that. Two of the interviews were with female security staff that stated the policy had changed after the last audit and they received training on the changes. Both noted female staff were no longer conducting cross-gender pat-searches. The Auditor observed no cross-gender pat-searches during the on-site visit. The facility has met substantial compliance.

(g): The facility's SAAPI policy states all prison staff, contractors, volunteers, and visiting officials shall announce their presence when entering a housing unit of the opposite gender as to avoid cross-gender viewing of inmates/detainees showering, performing bodily functions, and changing clothes. The Auditors observed announcements being made while on the tour and during revisits to facility areas. There are signs posted on the female housing unit's entry doors that states, "When entering this area all males must announce themselves." Staff are also provided training on unannounced rounds to help assure compliance with the standard that limits cross-gender viewing. The majority of the random interviews with detainees stated staff of the opposite gender announce themselves when entering the housing areas. Interviews with random staff acknowledged making announcements and the requirement to make the announcement upon entering a housing unit of the opposite gender. The random staff and detainee interviews indicated the detainees do not have privacy to allow detainees to shower, perform bodily functions and change clothing without employees of the opposite gender viewing them. Male staff interviewed stated they understand the need for privacy and when entering a female housing unit, they keep their head down and not look into the showers or bathrooms and announce male on the block. Ten of the 18 random detainee interviews indicated that staff of the opposite gender can see them showering, using the toilet, and when changing clothes. The cross-gender viewing in the female housing units is a result of the facility policy for the cell doors to be open at all times during the day and second shift to eliminate the need to continue opening and closing the cell doors. In general, there is visible cross-gender viewing of toilets and showers throughout the facility. The Auditors observed detainees showering with no privacy and utilizing the toilets performing bodily functions. (b) (7)(E) [redacted]

Does Not Meet (g): Throughout the facility, there is cross-gender viewing of detainees in showers, utilizing the toilet, and changing clothes. The facility must allow detainees privacy from cross-gender viewing for showering, performing bodily functions, and changing clothes. Below is a breakdown of the cross-gender viewing areas identified by the Auditors as an issue:

- Admissions Area: cross gender viewing of the toilet in the large holding cell and in the change-over room
- F Block – first bathroom has toilets and showers in full view; bathroom near D dorm has toilet and shower in full view; bathroom near I Dorm has the first toilet on each side and the showers in full view; and bathroom by F Dorm has toilets and showers in full view.
- OS2 (Old Segregation): shower has visibility

- Hallway Cells: the toilets in the four cells can be viewed.
- H Block: In the A Unit, the showers are visible. In the B Unit, the showers are visible; cell toilets can be seen by staff and the control booth staff. In the C Unit the showers are visible; cell toilets can be seen by staff and the control booth staff. In the A Unit, the showers are visible.
- Female Behavior Adjustment Block: the shower curtains were not high enough allowing viewing of female breasts while showering.
- Cross Hall Area: Segregation A toilets visible, Segregation B toilets visible, Segregation C toilets visible.
- New North Block: Unit NNA the showers are visible; the frosting on the window is not adequate. Unit NNB-32 the showers are visible; the frosting on the window is not adequate. Unit NNC the showers are visible; the frosting on the window is not adequate, and toilets are visible. Unit NND the bathrooms are visible; the privacy walls are too short. Unit NNE the showers are visible; the frosting on the window is not adequate. Unit NNF the showers are visible; the frosting on the window is not adequate, and toilets are visible.
- East Block: Unit EA the showers are visible; the frosting on the window is not adequate, and toilets are visible; the privacy walls are too short. Unit EB the showers are visible from the hallways; the frosting on the window is not adequate, and toilets are visible. Unit EC the showers are visible; the frosting on the window is not adequate, and toilets are visible. Unit ED toilets are visible
- Delta Dorm Block: Unit A the cell toilets are visible, and the shower curtains are inadequate. The shower in the middle of the unit like others, there is no curtain, so the detainee is totally exposed. Unit B-32, the cell toilets are visible, and the shower curtains are inadequate. Unit C the shower curtains are inadequate.
- Bravo Dorm Block: Dorm IB1 toilets and showers are visible. Dorm IB2 the toilets and showers are visible.
- M Block: All the dorm's (MA, MB, MC, MD, ME, MF) showers and toilets allow visibility and cameras allow cross gender viewing during clothing changes.
- New South Block: Unit SSA, the showers and toilets are visible. Unit SSB, the showers and toilets are visible. Unit SSD, the showers and toilets are visible.
- Echo Male Behavior Adjustment Unit: Unit A showers are visible. Unit B toilets are visible. Dorm C, the shower curtains are not adequate. The facility had created a protype shower panel in the first shower.
- South Block: Unit SA showers are visible on each level. Unit SB showers visible on each level and from the hallways. Unit SC toilets and showers are visible. Unit SD the toilets and showers are visible. Unit SE the showers and toilets are visible. Unit SF the toilets and showers are visible.
- (b) (7)(E) [redacted]

Corrective Action Taken (g): In September 2019, the facility provided the Auditor with directives that to protect detainees from cross-gender viewing, the facility would close cell doors in the secure housing units when a detainee requests to perform bodily functions; install shower curtains in housing units to provide privacy for showering; and install privacy mesh on shower doors located in secure management units. Photographs were provided to show the installation of shower curtains, partitions, and frosted film on windows to eliminate cross-gender viewing. (b) (7)(E) [redacted] the toilets and shower area shall be blurred from view, and detainees and inmates classified to the dormitory style housing unit shall change clothing in the shower/toilet area out of view of the cameras. The facility also provided direction through the update of Post Orders that states, "Upon request, inmates are to be provided privacy while using the toilet on the housing units that have cell doors. Temporarily, one cell in each pod (middle cell/bottom tier) will be designated as the only cell that can be shut upon request for bathroom use. The door will remain shut until the cell is requested for use. The following pods will utilize these specific cells for bathroom use: B-Pod – Cell#5, C-Pod – Cell #5, E-Pod-Cell 8 & F-Pod-Cell #1. Note: Anytime a cell is closed for more than 15 minutes, a staggered round must be conducted and documented via clock round. Staff must be vigilant to ensure only one inmate is in the cell when the door is closed." This procedure was explained by officers working the housing units and confirmed during interviews with detainees. The Auditor observed the practice while conducting the tour. Within the dorms, there is a posting (English and Spanish) instructing the detainees to change their clothes in the bathroom area to eliminate cross-gender viewing. The facility also installed shower curtains and privacy mesh to provide privacy during showers and eliminate the potential for cross-gender viewing. The facility also placed frosted film on the shower and housing unit windows to eliminate the potential for cross-gender viewing. During the tour, the Auditor observed the film in some of the housing units was not adequate due to the film placement. The facility corrected this during the CAP reinspection on-site visit by adjusting/replacing film on those windows. The Auditor retoured those areas to view the film placement, which confirmed the film placement has eliminated the potential for cross-gender viewing. The security staff stated during interviews that the facility has shower curtains that afford the detainees privacy. A security briefing to staff directed the staff that "all employees, volunteers, official visitors, contractors, and contract employees must announce their presence when entering a housing unit with inmates of the opposite gender, excluding exigent circumstances (i.e., responding to a medical emergency, back-up, etc.). The purpose of this direction is to provide inmates of the opposite sex of the staff entering the unit to be able to dress if showering, using the toilet, etc." The facility has met substantial compliance.

(i): The facility's SAAPI and Searches policies outline if prison staff have concerns regarding the gender of the detainee, they shall notify their supervisor. The supervisor shall coordinate with the medical authority to have the detainee evaluated by a licensed medical professional to determine the gender of the detainee. Only a licensed medical professional shall conduct body cavity searches. All random staff interviewed, except two, stated they had not conducted or been witness to a search or physical examination to determine a detainee's gender. Of the two staff that indicated they had conducted a search for this purpose, one indicated they had strip searched the detainee and the other indicated the detainee was stripped down to the undergarments. Staff were aware of the policy and that detainees would be referred to medical for determination. A memo from the PSA Compliance Manager to file stated no visual body cavity searches had been conducted by medical or non-medical personnel during the audit year. There were no transgender or intersex detainees housed during the onsite audit to interview.

Does Not Meet (i): The facility does not attempt to determine gender through conversations with the detainee, by reviewing medical records, or if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. The facility policy and practice are not in compliance with the standard. The policy and practice are for the supervisor to coordinate with the medical authority to have the detainee evaluated by a licensed medical professional to determine the gender of the detainee which is not part of a standard medical examination that all detainees undergo as part of intake or other processing procedure conducted by a medical practitioner. The facility needs to develop a practice to try to determine a detainee's gender through conversations with the detainee, reviewing medical records, or if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. The developed practice needs to be documented in policy and staff trained on the policy and procedure.

Corrective Action Taken (i): The facility provided in September 2019 an update to policy 2.1 that states, "Strip Searches shall not be conducted by Prison staff to solely determine the gender of an inmate. If the inmate/detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all inmates/detainees undergo as part of intake or other processing procedures conducted in private, by a medical practitioner." A PREA Booster training was conducted in August 2020 for all staff that included the policy change. The Auditor reviewed eight staff training files and a training roster that verified the training. The facility has met substantial compliance.

(j): The facility's SAAPI policy states, searches of all types shall be conducted in accordance with prison procedures and training, including cross-gender searching requirements. The interviews with the Training Supervisor confirmed the training practices, as well as the review of the training lesson plan, "Contraband and Searches, Basic Training." The lesson plan is the Pennsylvania Department of Correction's (PDOC) lesson plan utilized at their training academy and has one slide on transgender/intersex searches. A training computer print-out provided indicated that 469 security staff had completed the required training in January 2019. The facility has 665 staff who may have recurring contact with detainees and of that 494 are security staff. The documentation provided demonstrated that all staff have not been trained on searches; not even all the security staff. Training list of another class, Clothed and Unclothed Searches, which also addresses transgender searches was conducted in January 2019. Of that class, the records indicated that 632 staff attended the training. Random staff interviewed were knowledgeable on conducting searches and cross-gender searches. Staff were able to explain the process of conducting a cross-gender pat-down search by utilizing the back/blade of hand; only 4 of the 14 random staff interviewed acknowledged receiving training on transgender and intersex pat-down searches. In the review of six staff training records, only two staff attended the required training. Documentation was provided of eight ICE staff training files which documented training of searches through lesson plan "Cross-Gender, Transgender, and Intersex Searches."

Does Not Meet(j): Not all staff are trained on conducting cross-gender pat-down searches and transgender/intersex pat-down searches as documented through the training list provided, staff training files, and interviews with staff. All staff must be trained on conducting cross-gender pat-down searches and transgender/intersex pat-down searches. The facility needs to conduct training with staff that have not completed training for cross-gender pat-down searches and transgender/intersex pat-down searches. The training must be documented.

Corrective Action Taken (j): In September 2019, the facility stated staff would conduct training on cross-gender and transgender pat-searches. A PREA Booster training was conducted in August 2020 for all staff that included the changes in the policy for conducting cross-gender and transgender searches. The Auditor reviewed eight staff training files and a training roster that verified the training. The five security staff interviewed stated that pat-down searches are conducted by the same gender staff and the policy had changed to reflect that. The staff acknowledged the training occurred during annual in-service through a training video. They stated that a pat-down search of a transgender detainee would occur after asking the detainee their gender preference for the search and you would use the blade of the hand. The facility has met substantial compliance.

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

Outcome: Does not Meet Standard

Notes:

(a): The facility's SAAPI and Intake Processing policies state inmates/detainees will be provided orientation in writing in a language that they understand and/or, if unable to read, shall have the orientation presented to them verbally by the counselor. Policy also states staff will assist detainees that are deaf, visually impaired, and/or otherwise disabled or that have limited reading skills. The detainee shall be asked if he or she understands the orientation and shall acknowledge by signature that understanding. The facility has the Inmate/Detainee Handbook, ICE Zero Tolerance Poster, Reporting Memo, and ICE Sexual Abuse and Assault Awareness pamphlet available in English and Spanish. The ICE National Detainee Handbook is also available. The Warden indicated the facility utilizes staff interpreters, who are bilingual as a collateral duty, a TTY phone for the hearing impaired, a language line is available for use, and there is PREA information in the Inmate/Detainee Handbook in English and Spanish. The interview with the intake staff officer indicated detainees deaf or hard of hearing would have written materials available; detainees who have intellectual, psychiatric, or speech disabilities would have counselor, medical, and/or mental health staff assist with communication, and detainees who have limited reading skills, staff would read the information and the video to provide the information. The two detainees interviewed that had low cognitive skills indicated that mental health staff provided the PREA information to them verbally and explained the information. The two detainees that could not read or write indicated they did not get PREA information at intake and can't read or understand the information on the housing unit bulletin boards. They ask other detainees if they have a question or need information. The Auditor interviewed intake officers on two different shifts, staff indicated there was no language/translator line. The phone in intake is available for the service but the system was not connected. Staff could not address how detainees that are deaf or hard of hearing would be provided the information. Eleven of the 14 random staff interviewed indicated they could provide PREA information to detainees through the Inmate/Detainee Handbook in English and Spanish for detainees hard of hearing or deaf; detainees that have intellectual, psychiatric, or speech disabilities would have the information explained to them verbally by going through the information slowly and at a level they would understand. There were no consistent answers on whether a PREA video is played for the detainees; about half the staff indicated no knowledge of a video and the other staff indicated a video is played at intake or in the housing unit.

Does Not Meet (a): The facility must ensure detainees with disabilities (including deaf or hard of hearing and those who cannot read) have an equal opportunity to participate in or benefit from all the agency and facility's efforts to prevent, detect, and respond to sexual abuse. The facility needs to develop procedures to provide deaf and illiterate detainees PREA information in a manner they understand.

Corrective Action Taken (a): The facility provided in September 2019 an update to policy 2.1 that states, "Prison admission areas currently contain the procedures for utilizing interpretation services via telephone. Staff, lead workers and supervisors will receive additional training on when to utilize interpretation services. Use of an interpreter will be documented in the jail management system. In addition to the policy and procedure being updated, the following shall occur in English and Spanish: Installation of dedicated televisions to continuously provide PREA orientation and notification in all prison admission areas; Installation of the PREA orientation video and pamphlet on detainee electronic tablets; Installation of the York County Prison and PBNDS handbook on detainee electronic tablets; The stocking and maintaining of PBNDS handbooks in admission areas to provide to detainees; and Closed captioning should be used for tablets and televisions when necessary for deaf or hard of hearing detainees or inmates." The staff interviews stated for deaf or hard of hearing detainees they would provide written materials for the detainee to read, read the materials to them if they could not read, and/or utilize a translator. They stated for blind or low vision they would read the materials to the detainees. The staff also acknowledged there is a video during orientation that is in English and Spanish the detainees could watch and listen to. If the detainee had intellectual, psychiatric, or speech disabilities, the staff would explain the PREA information on a level they understand, use a picture dictionary, and/or have the facility's Crisis Intervention team utilized to explain the information. The Auditor observed the facility installed televisions for the intake area that plays the PREA video in English, Spanish, and is close-captioned. The facility has tablets available to the detainees in the housing units that contain the facility's Inmate/Detainee Handbook, the ICE National Detainee Handbook, and PREA information in English and Spanish. The detainees are to stay in the area until the video is played until completion. Male detainees see the PREA video and receive PREA orientation while in the general intake area. Female detainees are taken to the female housing unit intake cell for this process. The facility provided further training with the intake staff on the topic Language Line- Phone Translation documented through a Staff Training Roster form with staff signatures. The facility has met substantial compliance.

(b): The facility has the Inmate/Detainee Handbook, ICE Zero Tolerance Poster, Reporting Memo, and ICE Sexual Abuse and Assault Awareness Pamphlet available in English and Spanish. The ICE National Detainee Handbook is also available in seven languages (Simplified Chinese, Portuguese, Haitian, Hindi, English, Spanish, and Arabic). The Warden indicated the facility utilizes staff interpreters, a language line is available for use, and there is PREA information in the Inmate/Detainee Handbook in English and Spanish for those detainees with language barriers. The ICE PREA Zero Tolerance posters in English and Spanish, containing the name of the facility PSA Compliance Manager are posted on bulletin boards in the housing units. Also, posted are Sexual Abuse and Assault Awareness pamphlet and the Reporting Memo that includes reporting methods and emotional support contact information in English and Spanish. The ICE National Detainee Handbook includes a section (language identification guide) in the front of the handbook which outlines multiple languages to assist detainees who do not speak English or Spanish. During the audit, 11 interviews were conducted with limited English proficient (LEP) detainees. The language line was utilized for detainees that spoke Spanish (10) and Mandarin (1). Only 5 of the 11 detainees interviewed stated they were provided information through a facility staff interpreter who is bilingual. Two detainees interviewed indicated the information was provided through other detainees used as interpreters (Mandarin and Spanish). The other four detainees stated they received the information on paper in a language they understood but staff did not explain the information. During the tour, the Auditor met with four Chinese detainees who stated they were not provided a handbook in Chinese and a detainee interpreter was used at intake for confidential PREA questions. The intake staff indicated there is no translation/interpretation line to utilize and they will try to obtain a staff interpreter. If there is no staff interpreter available, they give the detainee the PREA paperwork and the Inmate/Detainee Handbook to read and have them sign for it even if it is not in a language they understand. If the detainee does not speak English or Spanish, they are given the information in English. Upon review of a sexual harassment investigation, the case was substantiated by the facility investigator against a staff member. However, the PREA Coordinator overturned the outcome noting a language barrier between the alleged staff member and the detainee during the alleged incident. The case being overturned on language barrier reinforces the non-compliance of 115.16. Four of the random staff interviewed indicated that another detainee or inmate is utilized for interpretation services and two indicated that counselors utilize inmate interpreters if needed during the classification process. A random detainee that was interviewed stated he is used as an interpreter in classification and intake.

Does Not Meet (b): The facility must ensure detainees with limited English proficiency have an equal opportunity to participate in or benefit from all the agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The facility needs to provide PREA information in a language they understand. Staff are not utilizing and providing the ICE National Detainee Handbooks to detainees in a language they understand. The facility needs to provide LEP detainees an equal opportunity to participate in or benefit from all of the agency and facility's efforts to prevent, detect, and respond to sexual abuse. This should include interpretive services that enable effective, accurate, and impartial interpretation from intake, to postings in the housing units, provided education materials, and through the investigation process. Also, the facility needs to provide the ICE National Detainee Handbook to detainees in a language they understand.

Corrective Action Taken (b): The facility provided in September 2019 an update to policy 2.1 that states, "Prison admission areas currently contain the procedures for utilizing interpretation services via telephone. Staff, lead workers and supervisors will receive additional training on when to utilize interpretation services. Use of an interpreter will be documented in the jail management system. In addition to the policy and procedure being updated, the following shall occur in English and Spanish: Installation of dedicated televisions to continuously provide PREA orientation and notification in all prison admission areas; Installation of the PREA orientation video and pamphlet on detainee electronic tablets; Installation of the York County Prison and PBNDS handbook on detainee electronic tablets; The stocking and maintaining of PBNDS handbooks in admission areas to provide to detainees; and Closed captioning should be used for tablets and televisions when necessary for deaf or hard of hearing detainees or inmates." The facility has purchased handheld translation devices to assist staff with detainee communication. A memo to staff directed that the handheld translation device, a staff member, or the language translation line available through the telephone system will be used for casual conversations as well as the initial gathering of confidential/sensitive information

from detainees (PREA, assaults, medical concerns, etc.). The Auditor asked staff during the tour to demonstrate the use of the handheld translation devices; the staff were knowledgeable on how to operate the device. The PREA video is available in English and Spanish. A notice to staff stated "Inmates/Detainees will be given ample opportunity to view a new PREA orientation video in Admissions in a language of their choice. Admissions staff will instruct new intakes to watch the video and will be able to view for at least one full cycle (and entire English and an entire Spanish viewing)." The Auditor observed three detainee intakes, during which the intake staff did not ask the detainee the language they understood. Each intake staff member handed orientation handouts to the detainees without asking the detainee their language of preference. The Auditor asked each detainee if the information provided was in a language they understood and if they understand the PREA information after each intake. One detainee was provided PREA information in Spanish and the detainee's language was Spanish. The second detainee was handed orientation information in Spanish and the Auditor asked him if it was in a language he could understand. He answered he was not sure because he could not read. The staff member did not ask if the detainee could read the materials or if he understood them. The third detainee was provided orientation materials in English; he could understand some English verbally; however, he could not read English as his language of preference was Spanish. Staff in Admissions indicated they have the facility Inmate/Detainee Handbooks available in English and Spanish. The ICE National Detainee Handbook is available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese); however, the facility has only seven of these languages available (Simplified Chinese, Portuguese, Haitian, Hindi, English, Spanish, and Arabic), which are the most common languages encountered at the facility. The staff know how to obtain the handbook in other languages if needed through downloading or obtaining from ERO. The facility has provided direction for the use of the ERO Language Line which is posted above the phone in the Admissions area. Staff are to document the use of the language line on the Language Line Phone Translation Log Sheet. The Auditor interviewed 11 detainees; 6 detainees stated they did not receive PREA information in a language they understood. The Auditor reviewed the same detainee's detention files, which showed six detainees received the PREA orientation information in a language they could not understand. This even included two English speaking detainees receiving the information in Spanish. The other detainees' languages were Russian, Vietnamese, Kinyalrwancla, and Spanish. The facility does not ensure LEP detainees have an equal opportunity to participate in or benefit from all the agency and facility's efforts to prevent, detect, and respond to sexual abuse. The facility does not meet the standard.

(c): The facility has bilingual staff interpreters as a collateral duty. The facility has available to them the ERO Language Access Resource Center for interpretation services. Random staff interviewed was not aware of the available interpretation services. Two of the allegations were reported by LEP detainees; in both cases staff interpreters were utilized for communication. Twelve of the random staff interviews indicated they would not utilize another detainee, a minor, the alleged abuser, a detainee witness, or a detainee who has a significant relationship to the alleged abuser for interpretation. Two staff indicated they would use another detainee. Through staff interviews and the absence of policy language, the Auditors could not determine if a detainee expresses a preference for another detainee to provide interpretation and the facility determines that such interpretation is appropriate and consistent with DHS policy on all three shifts, the detainee would be provided another detainee to interpret. The majority of LEP detainees interviewed indicated they would communicate through another detainee that spoke English to tell an officer the need for the services.

Does Not Meet (c): The facility should allow a detainee who expresses a preference for another detainee to provide interpretation and the facility determines that such interpretation is appropriate and consistent with DHS policy on all three shifts, the detainee would be provided another detainee to interpret. Through the staff interviews and absence of policy language, the Auditors could not determine compliance. The facility needs to provide policy and procedure training with staff of when a detainee interpreter may be used, and the availability of the language line services.

Corrective Action Taken (c): In September 2019, the facility stated training would be conducted with staff when a detainee interpreter may be utilized, and the availability of the language line services. A PREA Booster training was conducted in August 2020 for all staff that included when a detainee interpreter may be utilized, and the availability of the language line services. The Auditor reviewed eight staff training files and a training roster that verified the training occurred. The security staff interviewed all stated they would not use a detainee, the alleged abuser, and/or a detainee who has a significant relationship to the alleged abuser to translate even if requested by the detainee. The facility also provided training specific to the Language Lines-Phone Translation for the staff that work in Admissions. The training was documented through a Staff Training Roster with signatures. The facility has purchased handheld translation devices to assist staff with detainee communication. A memo to staff directed that the handheld translation device, a staff member, or the language translation line available through the telephone system will be used for casual conversations as well as the initial gathering of confidential/sensitive information from detainees (PREA, assaults, medical concerns, etc.). The Auditor asked staff during the tour to demonstrate the use of the handheld translation devices; the staff were knowledgeable on how to operate the device. The facility has met substantial compliance.

Recommendation (c): The facility has provided training with staff through the annual training and the PREA Booster training on when a detainee interpreter may be utilized; however, the four staff interviewed still stated they would not use another detainee if the detainee requested it. The staff need a refresher training or security briefing to reenforce when a detainee may be utilized for translation services.

§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): Through a review of the Personnel policy, it was determined that the facility has established a system of conducting criminal background checks for new employees to ensure they do not hire or promote anyone who engaged in sexual abuse of another; been convicted of a sexually violent crime; and been convicted of a civil complaint regarding sexual abuse. The facility conducts the hiring and criminal background check process for the facility's employees, contractors, and volunteers. The policy states if the employee was a former correctional employee, all efforts shall be made to contact the previous facility(s) to determine if any substantiated allegations of abuse occurred or the employee

resigned during a pending investigation of sexual abuse. The Human Resources Department personnel interview indicated this information is asked as part of the background check and the facility's Intelligence Office sends the Consent to Release Information for PREA Compliance to other institutions for information. The information can't be part of the application per the state's "Ban the Box" movement to eliminate discrimination during the hiring process. The Human Resources Department will receive a Certification Form from the Intelligence Office stating whether the applicant can be hired or not. If the facility is aware of an applicant or a staff for promotion has engaged in sexual abuse, they would not be hired or promoted per the interview with Human Resources personnel. The Volunteer Application states the volunteer must report to the YCP any criminal charges or accusations of sexual abuse, assault, or harassment, lodged against a volunteer by any person or entity. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a security shift supervisor or administration. The facility also has in place a system, DataWorksPlus, that is connected to the Pennsylvania State Police as a central repository for criminal arrests. This system provides notification if an employee is arrested. An Auditor randomly selected six facility employee files to review for the administrative adjudication check (the three questions) as part of the hiring process paperwork and the background check prior to hiring. The employee files were in compliance.

Through a review of Executive Order 10450 Security Requirements for Government Employment and the Office of Personal Management Section Part 731 Suitability; and ICE Policy system Directive Title ICE Personnel Security and Suitability Program, it was determined that the agency has established a system of conducting criminal background checks for new ICE employees, contractors, and volunteers who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The interview with the Unit Chief of Personnel Security Unit (PSU) stated that all new employees are required to answer the three questions to ensure that they have not: engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt, or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse; and have not been civilly or administratively adjudicated to have engaged in the activity described within the standard. He indicated this is completed on the job application form and at the front of the interview. This is also reviewed as part of the background process. The standard addresses the utilization of this process in the promotional system, after reviewing the above policies, and during the SDDO interview, if any employee or contractor were involved in any misconduct of this nature, they would not be employed or contracted by DHS. Employees also have a continuing affirmative duty to report. The Unit Chief of Personnel stated staff are required to report any misconduct to their supervisor and to the Joint Intake Center (JIC) managed by ICE. This requirement is shared with staff in the PREA training. If the agency receives an arrest notification, this will be forwarded to OPR Investigation Unit and ICE Labor Relations.

Does Not Meet (a): The facility does not conduct background checks on contractors and volunteers. The facility's Personnel policy or staff interviewed could not address if the background check included whether the individual has been civilly or administratively adjudicated to have engaged 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 refuse. The facility must establish a system for conducting background checks on volunteers. The background check process for contractors and volunteers needs to review whether the individual has been civilly or administratively adjudicated to have engaged 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 refuse.

Corrective Action Taken (a): The facility provided in September 2019 an update to policy 2.1 that states, "Prior employment in any type of Prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997) to include state facilities for persons who are mentally ill, disabled, or intellectually disabled, or chronically ill or handicapped; residential care or treatment facilities for juveniles; and facilities that provide skilled nursing, intermediate, or long-term care, or custodial or residential care will be further investigated to ensure that the candidate has not been found to have any of the following: Has engaged in sexual abuse in a Prison, jail, lockup, community confinement facility, or other institution; Has been convicted or civilly or administratively adjudicated for 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." The facility also noted in the CAP that the policy has been changed to reflect the practice of initial background (criminal and civil) checks along with changes to subsequent background checks for all staff, volunteers and contractors that occur at least every 5 years. This tracking log shall be maintained in the Security Office by the Intelligence and Security Commander. The Auditor reviewed a volunteer file that documented the initial background check prior to providing services and the last background check on April 7, 2021. Also, the facility provided the Approved Volunteers Training and Clearance Log which documented the dates of the background checks completed. The interview with the Lieutenant explained that the initial background check is completed prior to approval for facility entrance. The background checks are to be updated every two years. The Chaplain's background checks were completed in 2019, when all facility staff background checks were completed. The review of the Approved Volunteers Training and Clearance Log showed the two-year background checks have not been completed, other than the Chaplains. It was explained that the facility has not authorized volunteers into the facility due to COVID protocols. When volunteers are able to start providing services, the background checks will be updated. The facility also has initiated requiring volunteers to complete the York County Prison PREA Employment, Volunteer and Promotional Questionnaire that asks the individual whether the individual has been civilly or administratively adjudicated to have engaged 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 refuse. This was documented in two volunteer files, one provided during the CAP process and one during the on-site visit. The facility has met substantial compliance.

Recommendation: The facility's directive on the Approved Volunteers Training and Clearance Log that states background checks every two years conflicts with the policy language requiring background checks every five years. The facility should update the Approved Volunteers Training and Clearance Log directive or the policy to reflect the facility's actual practice and eliminate the conflicting procedure.

(c)(d): The facility's Personnel policy requires a criminal background record check for all new hires to ensure the candidate is suitable for hiring. The facility's background check includes a criminal background check and a driver license records check. The results of the criminal record check will be reviewed by Prison Administration in conjunction with the County Human Resources Department and a decision will be made on eligibility for employment. The facility does not address the five-year requirement for background checks for those facility staff who have contact with detainees. The Auditors randomly selected six employee files to review for the criminal background checks prior to hiring; all were completed prior to the hiring date however the updated background checks were not completed. The facility's policy does not address background checks for contractors. The Human Resource interview stated it is not a human resource function, as it is conducted through the Intelligence Office. The interview with Human Resources stated contractors are cleared through background checks prior to entering the facility. The facility was unable to provide documentation of contractors' background checks.

Background checks of ICE employees are conducted through the PSU prior to an ICE employee or contractor being approved for hire or a volunteer approved to provide services. The agency conducts personnel security reviews on everyone that works for ICE by ensuring they are suitable for the position selected and they maintain a high level of character. During the background process the applicant, employee or contractor is asked questions directly related to sexual abuse in confinement settings enumerated in the standard, these questions are asked both in a written form and in person by the assigned investigator who conducts the interviews. The background check consists of a National Agency Check (NAC), education checks, residence checks, personal reference checks, and fingerprint check. The background coverage period is five years. The interview with the Contracting Officer's Representative (COR) and the Unit Chief of PSU stated that contractors are background checked by their company and asked the three questions during the application process. The agency also conducts background checks on the contractors. The background coverage period is determined by the risk of the position. Low or moderate risk positions have background checks completed every ten years. Positions that are considered high risk have background checks every five years. The background check for a contractor consists of National Agency Check (NAC), personal subject interview, employment checks, education checks, residence checks, credit checks, fingerprint check, and law enforcement check. The Auditor completed a request through PSU for background information on six ICE facility staff. The Auditor confirmed the background investigations for six ICE staff at the facility all were within the specified time limit of five years from the date of entry or the initiation of PREA.

Does Not Meet (c)(d): The facility does not conduct five-year updated background checks on facility staff. The background check process for contractors could not be confirmed as documentation was not provided to the Auditors. The facility must conduct updated background checks on staff every five-years and background checks on contractors prior to assignment.

Corrective Action Taken (c)(d): The facility provided in September 2019 an update to policy 2.1 that states, "The Intelligence and Security Commander (or supervisor designee) shall complete the following for all new hires and at least every 5 years in coordination with the Human Resource Office as law allows: Check on the applicant's name, home address, and telephone number(s) against each of the facility's inmate visit or, telephone list, tablet and mail logs; Criminal History information shall be investigated using the following methods: Prison database; Federal Bureau of Investigation Records; Pennsylvania State Police Records. The Intelligence and Security Commander shall maintain an active log documenting each staff member, contractor and volunteer's date of clearance and approval. All employees, contractors and volunteers must report all arrests in accordance with the Code of Ethics." The facility also noted in the CAP that the policy has been changed to reflect the practice of initial background (criminal and civil) checks along with changes to subsequent background checks for all staff, volunteers and contractors that occur at least every 5 years. This tracking log shall be maintained in the Security Office by the Intelligence and Security Commander. The facility completed background checks on all staff in 2019. The facility provided the Background Check roster for Prime Care Medical staff that documented all contractors received a background check in 2019. The Auditor reviewed five contractor files documenting background checks. The facility has met substantial compliance.

§115. 21 - Evidence protocols and forensic medical examinations

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

Notes:

(e): The Warden indicated the facility is responsible for administrative investigations and criminal investigations would be referred to the PSP. All allegations are reported to the PSP and ICE, including to the AFOD and ICE staff at the facility for investigation and further action as stated by the PSA Compliance Manager and the Investigator. The facility does have a MOU with the PSP. There was no documentation that the facility has requested investigating agencies to follow the requirements of this standard when investigating an allegation.

Does Not Meet (e): There was no documentation that the facility has requested that investigating agencies follow the requirements of this standard. The facility must request that investigating agencies follow the requirements of the standard when conducting investigations.

Corrective Action Taken (e): The facility made a formal request to the PSP for the agency to follow the requirements of the ICE SAAPI standards by an email to the agency. The PSP responded through an email that stated, "Yes, we do follow similar protocols for sex investigations both in and outside the prison. We always use a SAFE/SANE nurse at York Hospital for those types of investigations, including those we obtain from the prison." The facility has met substantial compliance.

§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:

(c): On the facility's website, https://yorkcountypa.gov/courts-criminal-justice, states all allegations of sexual abuse and assault will be investigated thoroughly in order to provide prompt medical and administrative intervention to those involved. The website does not provide the investigative protocols or does the facility make the protocol available to the public in another method. ICE's protocol is posted on the agency's website; www.ice.gov/prea. The agency's website includes information on the agency's PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE National Detainee Handbook, ICE PREA Zero Tolerance poster, and Sexual Abuse and Assault Awareness pamphlet.

Does Not Meet (c): The facility does not make the investigative protocol available to the public through the website or another method. The facility must make the investigative protocol available to the public through the facility's website or another method.

Corrective Action Taken (c): The facility has posted the investigative protocols on the facility's website under the Prison Rape Elimination Act folder. The Auditor reviewed the website for compliance. The facility has met substantiated compliance.

§115. 31 - Staff training

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

Notes:

(a)(b)(c): The facility's SAAPI policy outlines that staff shall receive training about PREA and the SAAPI policy during the basic training academy PREA orientation session and as part of staff annual required training/orientation hours. The Deputy Warden of Centralized Services/designee is responsible for initial and yearly training of staff. The training lesson plan, PREA/SAAPI/Sexual Harassment from the PDOC addressed the zero tolerance policy; definitions and examples of prohibited and illegal sexual behavior; right of detainees and staff to be free from sexual abuse and from retaliation for reporting of prohibited and illegal sexual behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional signs of sexual abuse and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees; and requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. The policy states staff will be trained on how to prevent, detect, and report sexual abuse and harassment, including detainees with physical/mental disabilities and on the dynamics of sexual abuse/harassment in prison, the common reactions to the abuse, and how to avoid inappropriate relationships with detainees. The initial training occurs during the basic training academy, each staff member attends the academy pre-service training prior to being assigned to the facility. The training is also provided annually through the annual in-service training for all staff. Each staff employee is required to attend in-service annually. The Training Supervisor stated the staff receive PREA/SAAPI training annually, and the training lesson plan covers all the requirements of the standard. Training is documented in the electronic system and a report can be created documenting who attended the training, Report of People Attending. Fourteen random staff interviewed indicated they receive training annually and updated information through emails and shift briefings. The other two staff indicated they had not received any PREA training. The PAQ indicates that 665 staff who may have recurring contact with detainees and of that 494 are security staff. A computer print-out documenting the 2018 PREA training indicated that 515 staff had completed the required training in 2018. Of the six facility employee training files reviewed by the Auditor; five of the employees received PREA training in 2018. Four of the staff had not completed training for 2016 and 2017. The employees have not completed annual training per the policy or even documented refresher training every two years. Four of the employees showed initial PREA training in 2015. The two ICE employees training files reviewed showed training in 2018 and 2019 with initial training in 2015. The ICE DDO interviewed indicated the training is provided electronically on the PALMS system.

Does Not Meet (b): The facility has not demonstrated that all employees have attended annual PREA training per policy or refresher training every two years by the standard. Nor can the facility document that all employees were trained within one year of December 2016. All employees must complete PREA training annually per policy or refresher information every two years per standard. The training must be documented.

Corrective Action Taken (b): In September 2019, the facility stated, "Training for all staff, contractors and volunteers shall occur by November 30, 2019, on the updated SAAPI Policy and Procedure. Any staff, volunteers or contractors who do not receive the training by November 30, 2019, shall not be granted access to the secure prison or have contact with ICE detainees until the training has been completed and documented. These records shall be maintained in the employee database and S Drive training folders. Initial SAAPI trainings shall occur during every staff member basic training class and prior to any contractor or volunteer having access to the secure prison or having contact with ICE detainees. Yearly refresher trainings shall occur for every staff member, contractor, and volunteer. These trainings will continue to be documented via sign in sheet and through the Prison's employee database. Staff and contractors will receive a zero tolerance and first responder card explaining each that shall be worn with their County ID badge." PREA training was conducted in October/November 2019 and a PREA Booster training in August 2020 for all staff that included all the policy updates and general PREA information through lesson plan Prison Rape Elimination Act (PREA). A training roster also documented that staff were completing PREA training in 2021 with 181 staff completed the training prior to the on-site visit. The Auditor observed annual in-service PREA training occurring during the on-site visit. The Auditor reviewed eight staff training files that documented the PREA training. The staff interviewed acknowledged the PREA training occurs during annual in-service. The facility has provided each staff with a First Responder Card that outlines the first responder duties and the zero-tolerance policy. Staff are required to wear the card on their person during working. The facility has met substantial compliance.

§115. 32 - Other training

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

Notes:

(a)(b)(c): The facility's SAAPI policy outlines volunteers and contractors will receive training about PREA and the SAAPI policy during the PREA orientation session and as part of annual training/orientation hours. All contracted service providers, volunteers, and individuals who use prison resources shall receive information regarding sexual harassment or sexual contact with inmates/detainees during the orientation session and via pamphlet. The contractors and volunteers receive training through a PowerPoint presentation of the Prison Volunteer and Orientation Training Lesson Plan Sexual Abuse/Harassment Prevention Section. The training covers announcements must be made upon entering a housing unit of the opposite gender, zero tolerance standard, reporting requirement to immediate supervisor or the Prison Administration, that all allegations will be investigated thoroughly, there is no consensual sexual activity with detainees, and sexual activity with a detainee will result in criminal charges. Contractors and volunteers shall also be made aware of the zero-tolerance standard and criminal penalties for sexual

contact with a detainee. The Deputy Warden of Centralized Services/designee is responsible for initial and yearly training of contractors. The Staff Development and Training Manager is responsible for initial and yearly training of volunteers. The facility has contracts for healthcare with Prime Care Medical, commissary with Keefe Commissary, religious services with Good News Ministry, and education with LIU. Volunteers provide religious services, programming, and drug and alcohol intervention. The Training Supervisor stated all contractors and volunteers have been trained except for the Keefe contract staff. The Auditors observed the Keefe contract staff in the housing units having contact with detainees. When the Keefe staff was asked if they received PREA training, they indicated they had not received training. The facility could not provide the annual PREA training for the LIU education staff; the last training for education staff occurred in 2017. The healthcare staff receives PREA training, PREA: An Introduction and Overview, also through their agency electronic Relias system. The three contractors interviewed indicated all have received training prior to assignment through a classroom training with an instructor and a PowerPoint presentation. The two healthcare contractors stated they receive training annually through their agency. Contractors and volunteers must acknowledge receiving training through the signature on the Security Briefing Form. A sample of two contractors and two volunteers training files were provided to document compliance.

Does Not Meet (a): The facility does not provide training to all contract employees that have contact with detainees. The facility must provide training to all volunteers and contractors who have contact with detainees.

Corrective Action Taken (a): In September 2019, the facility stated, "Training for all staff, contractors and volunteers shall occur by November 30, 2019, on the updated SAAPI Policy and Procedure. Any staff, volunteers or contractors who do not receive the training by November 30, 2019, shall not be granted access to the secure prison or have contact with ICE detainees until the training has been completed and documented. These records shall be maintained in the employee database and S Drive training folders. Initial SAAPI trainings shall occur during every staff member basic training class and prior to any contractor or volunteer having access to the secure prison or having contact with ICE detainees. Yearly refresher trainings shall occur for every staff member, contractor, and volunteer. These trainings will continue to be documented via sign in sheet and through the Prison's employee database. Staff and contractors will receive a zero tolerance and first responder card explaining each that shall be worn with their County ID badge." Contractors attend annual in-service with facility staff. Volunteers are provided training through the York County Prison Volunteer and Contractor Orientation Form which must be read by the volunteer, reviewed with staff, and then signed and dated documenting the training. The volunteer completes the PREA-SAAPI test. The five contractor files and one volunteer file reviewed by the Auditor documented the training occurring in 2019 for individuals previously hired and training for the new contractors hired since the last on-site visit. Some of the contractors have completed training in 2021, the rest have not attended 2021 annual training yet. Interviews with three contractors (two from Keefe Commissary and the other from Prime Care Medical) all acknowledged PREA training, and the training occurs annually with facility staff. They also confirmed receiving the First Responder Card to carry that covers what steps to take when an incident is reported and the facility's zero tolerance policy. The facility met substantial compliance.

§115. 33 - Detainee education

Outcome: Does not Meet Standard

Notes:

(a)(f): The facility SAAPI policy states all inmates and detainees shall be notified during the intake process on how to report sexual harassment and abuse while incarcerated. This information shall also be included in the Inmate/Detainee Handbook. At intake, detainees are provided the YCP Inmate/Detainee Orientation to Preventing and Reporting Sexual Assault and Abuse in the Correctional Setting form (PREA form). This handout covers definitions of sexual abuse; zero tolerance; disciplinary charges for engaging in sexual abusive and assaultive behavior; reporting retaliation; consensual sex is prohibited; right to be safe; confidentiality; warning signs and red flags; reporting methods; can report anonymously; steps after reporting a sexual assault or attempted sexual assault; medical exam and healthcare services; investigation process; and emotional consequences of sexual abuse. The detainee must sign acknowledging the detainee has read and understood or a staff member read and explained to the detainee, and the detainee received a copy of the form. The form is available in English and Spanish. The detainee is also to receive the Inmate/Detainee Handbook, ICE National Detainee Handbook, and the ICE Sexual Abuse and Assault Awareness pamphlet as part of the intake orientation. The handbooks include information on sexual abuse prevention, sexual abuse reporting, sexual abuse treatment and counseling, and the grievance process. Staff indicated the PREA video is played during the orientation process. The Auditor observed two intakes during the on-site audit. The first intake observation was of a LEP detainee (Spanish) on the first day of the on-site audit. The intake staff were not bilingual nor communicated with the detainee through a language line or staff interpreter. There is no interpretation line available to the intake staff. They provided the PREA handout in Spanish to the detainee and had him sign before he had a chance to read or ask questions. The detainee was provided the PREA form. He was not provided an Inmate/Detainee Handbook, ICE National Detainee Handbook, and the SAAPI pamphlet. The PREA video was not shown or being played in the detainee waiting area. The detainee then was escorted to medical. The second intake observation was an English-speaking detainee on the third day of the onsite audit. The detainee was provided the PREA handout and staff provided a quick explanation of what the form was and then had the detainee sign the form. The detainee was not provided the Inmate/Detainee Handbook, the ICE National Detainee Handbook, or the SAAPI brochure. The detainee was escorted to medical, as well as the Auditor to observe the complete intake process. While in medical, the intake staff brought the Inmate/Detainee Handbook to the detainee. The Auditor asked the intake staff about the difference in the intakes observed; the staff indicated if there is time, they will provide a brief explanation. If a group of detainees arrive, they just hand them the PREA form because there is no time to explain or discuss due to the limited time to process the detainee and escort to medical. Of the detainees interviewed, 13 (4 limited English, 2 with disabilities, and 7 English speaking) stated they did not receive the Inmate/Detainee Handbook, the ICE National Detainee Handbook, or the SAAPI brochure at intake and 20 (8 limited English, 2 with disabilities, and 11 English speaking) indicated they received the PREA informational materials. The majority of the detainees stated they had not received handbooks or the pamphlets. Only nine of the detainees stated they saw the video. During the audit period, 4,893 detainees were booked at the facility.

Does Not Meet (a)(f): The facility is not consistently providing detainees PREA orientation materials during the intake process. The facility is not providing the detainee the Inmate/Detainee Handbook, ICE National Detainee Handbook, and the ICE Sexual Abuse and Assault Awareness pamphlet. The video was not playing during the times the Auditor was observing intake. There is no consistent process of providing

PREA orientation to detainees at intake. The facility needs to provide meaningful PREA orientation to all detainees at intake. The ICE National Detainee Handbook must be made available to the detainees or the information provided through an interpreter for LEP detainees when an ICE National Detainee Handbook is not published in their language.

Corrective Action Taken (a)(f): The facility in September 2019 as part of the CAP stated, "The following will occur regarding interpretation services, notification of PREA information in a language the detainee understands and the issuance of the PBNDS Handbooks. In addition to the policy and procedure being updated, the following shall occur: Installation of dedicated televisions to continuously provide PREA orientation and notification in all prison admission areas; Installation of the PREA orientation video on detainee electronic tablets; Installation of the York County Prison and PBNDS Handbook on detainee electronic tablets; The stocking and maintaining of PBNDS handbooks and ICE/ County SAAPI pamphlets in admission areas to provide to detainees. A notice to staff stated 'Inmates/Detainees will be given ample opportunity to view a new PREA orientation video in Admissions in a language of their choice. Admissions staff will instruct new intakes to watch the video and will be able to view for at least one full cycle (and entire English and an entire Spanish viewing)." The Auditor observed three detainee intakes. The staff did not provide the detainees the ICE National Detainee Handbook or ICE Sexual Abuse and Assault Awareness pamphlet, even though the handbook was available on the counter during the intake. All detainees were handed orientation handouts without asking the detainee the language of preference. The staff member did not explain the information or ask if the detainee had any questions. One detainee was handed orientation information; the Auditor asked him if it was in a language he could understand. He answered he was not sure because he could not read. The staff member did not ask if the detainee could read the materials or if he understood them. He had the detainee sign a form that the detainee received the information and understood the information. Although the facility has installed televisions for the viewing of the PREA video, the volume observed by the Auditor did not allow the detainee to hear the video, especially in the female intake area where the television is outside the intake cell on a wall on the opposite side of the hallway. The facility has tablets available in the housing units for the detainees that provide accessibility to PREA information and the facility's Inmate/Detainee Handbook in English and Spanish. The Auditor reviewed 11 detainee detention files which demonstrated inconsistency in the orientation materials provided to the detainees during intake and the lack of providing the ICE National Detainee Handbook. There is no consistent process of providing PREA orientation to detainees at intake. The facility needs to provide meaningful PREA orientation to all detainees at intake. The ICE National Detainee Handbook and the ICE Sexual Abuse and Assault Awareness pamphlet must be made available to the detainees. The facility does not meet the standard.

(b): The facility's SAAPI and Intake Processing policies state detainees will be provided orientation in writing in a language that they understand and/or, if unable to read, shall have the orientation presented to them verbally by the counselor. Policy also states staff will assist detainees that are deaf, visually impaired, and/or otherwise disabled or that have limited reading skills. The detainee shall be asked if he or she understands the orientation and shall acknowledge by signature that understanding. The facility has the Inmate/Detainee Handbook, ICE Zero Tolerance Poster, Reporting Memo, and ICE Sexual Abuse and Assault Awareness pamphlet available in English and Spanish. The ICE National Detainee Handbook is also available in seven languages (Simplified Chinese, Portuguese, Haitian, Hindi, English, Spanish, and Arabic). The Warden indicated the facility utilizes staff interpreters, a TTY phone for the hearing impaired, a language line is available for use, and there is PREA information in the Inmate/Detainee handbook in English and Spanish. The interview with the intake staff indicated detainees deaf or hard of hearing would have written materials available; detainees who have intellectual, psychiatric, or speech disabilities would have counselor, medical, and/or mental health staff assist with communication, and detainees who have limited reading skills staff would read the information and the video to provide the information. The two detainees interviewed that had low cognitive skills indicated that mental health staff provided the PREA information to them verbally and explained the information. The two detainees that could not read or write indicated they did not get PREA information at intake and can't read or understand the information on the housing unit bulletin boards. They ask other detainees if they have a question or need information. The Auditor interviewed the intake officers on two different shifts; staff indicated there was no language/translator line. A phone in intake is available for the service but the system was not connected. Staff could not address how detainees that are deaf or hard of hearing would be provided the information. An Auditor during the tour met with four Chinese detainees who stated they were not provided a handbook in Chinese and a detainee interpreter was used at intake for confidential PREA questions. The intake staff indicated there is no translation/interpretation line to utilize and they will try to obtain a staff interpreter. If there is no staff interpreter available, they give the detainee the PREA form and the Inmate/Detainee Handbook to read and have them sign for it even if it is not in a language they understand. If the detainee does not speak English or Spanish, they are given the information in English.

Does Not Meet (b): The facility is not providing detainees that are LEP, with limited reading skills, and with disabilities PREA orientation in formats they can understand. Staff are not utilizing and providing the ICE National Detainee Handbooks to detainees in a language they understand. The facility must provide the detainee notification, orientation, and instruction in formats the detainee can understand.

Corrective Action Taken (b): The facility in September 2019 as part of the CAP stated, "The following will occur regarding interpretation services, notification of PREA information in a language the detainee understands and the issuance of the PBNDS Handbooks. In addition to the policy and procedure being updated, the following shall occur: Installation of dedicated televisions to continuously provide PREA orientation and notification in all prison admission areas; Installation of the PREA orientation video on detainee electronic tablets; Installation of the York County Prison and PBNDS Handbook on detainee electronic tablets; The stocking and maintaining of PBNDS handbooks and ICE/ County SAAPI pamphlets in admission areas to provide to detainees. A notice to staff stated "Inmates/Detainees will be given ample opportunity to view a new PREA orientation video in Admissions in a language of their choice. Admissions staff will instruct new intakes to watch the video and will be able to view for at least one full cycle (and entire English and an entire Spanish viewing)." The PREA video is available in Spanish. Although the facility has installed televisions for the viewing of the PREA video, the volume observed by the Auditor did not allow the detainee to hear the video, especially in the female intake area where the television is outside the intake cell on a wall on the opposite side of the hallway. The facility has tablets available in the housing units for the detainees that provides accessibility to PREA information and the facility's Inmate/Detainee Handbook in English and Spanish. A notice to staff stated "Staff in Admissions indicated they have facility Inmate/Detainee Handbooks available in English and Spanish. The ICE National Detainee Handbook, available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French,

Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). The facility has the ICE National Detainee Handbook in seven languages (Simplified Chinese, Portuguese, Haitian, Hindi, English, Spanish, and Arabic) which is the most common languages encountered. The staff know how to obtain the handbook in other languages if needed through downloading or obtaining from ERO. The facility has provided direction for the use of the ERO Language Line which is posted above the phone in the Admissions area. Staff are to document the use of the language line on the Language Line Phone Translation Log Sheet. The facility has purchased handheld translator devices. A memo to staff directed that the handheld translation device, a staff member, or the language translation line available through the telephone system will be used for casual conversations as well as the initial gathering of confidential/sensitive information from detainees (PREA, assaults, medical concerns, etc.). The Auditor asked staff during the tour to demonstrate the use of the handheld translation devices; the staff were knowledgeable on how to operate the device. The Auditor observed three detainee intakes, during which the intake staff did not ask the detainee the language they spoke or understood. The staff member just grabbed the PREA information forms from the shelving and provided it to the detainee without asking the detainee their language of preference. The Auditor asked each detainee if the information provided was in a language they understood and if they understand the PREA information after each intake. One detainee was provided PREA information in Spanish and the detainee's language was Spanish. The second detainee was handed orientation information in Spanish and the Auditor asked him if it was in a language he could understand. He answered he was not sure because he could not read English or Spanish. The staff member did not ask if the detainee could read the materials or if he understood them. The third detainee was provided orientation materials in English; he could understand some English verbally; however, he could not read English as his language of preference was Spanish. The staff member had all the detainees sign a form that the detainee received the information and understood the information without ensuring their understanding. The Auditor interviewed 11 detainees; 6 detainees stated they did not receive PREA information in a language they understood. The Auditor reviewed the same detainee's detention files; the files showed six detainees received the PREA orientation information in a language they could not understand. This even included two English speaking detainees receiving the information in Spanish. The other detainees' languages were Russian, Vietnamese, Kinyalrwancla, and Spanish. The facility does not ensure detainees receive PREA orientation information in a language they understand. The facility does not meet the standard.

(e): ICE Sexual Abuse and Assault Awareness Pamphlet is posted on bulletin boards within the facility. The bulletin boards are accessible to the detainees in dorm settings. In the cell housing blocks, the PREA information was posted on bulletin boards in the hallways which was not accessible to the detainees. The pamphlet is not distributed at intake.

Does Not Meet (e): The facility does not make the ICE Sexual Abuse and Assault Awareness pamphlet available to the detainee through accessible posting or distribution. The facility needs to have the ICE Sexual Abuse and Assault Awareness pamphlet available to the detainees or distribute it to each detainee. The celled housing blocks need to post the information within the housing block to allow detainees access to the PREA information.

Corrective Action Taken (e): The facility has made available the ICE Sexual Abuse and Assault Awareness pamphlet to detainees by posting on the bulletin boards within the housing unit. Also posted were the ICE zero-tolerance and the Detention and Reporting Information Line (DRIL) posters on the bulletin boards. This was supported through photographs during the CAP period. The Auditor observed the ICE Sexual Abuse and Assault Awareness pamphlet posted in the housing units. The facility met substantial compliance.

§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): The facility's SAAPI policy states staff investigating allegations of sexual abuse or harassment have training to ensure compliance with PREA. The Training Supervisor interviewed stated that investigators do not receive the specialized training at the facility; they attend a PDOC training. The lesson plan utilized is PDOC PREA Training for Correctional Investigations. It is a 12-hour course. The PAQ states the facility has five investigators who have received training on sexual abuse investigations and cross agency coordination. There are five trained investigators; three received their training in June of 2018 and the other two in December 2018. The Auditors reviewed the nine closed investigation files; six of those were conducted by investigators with no training. The one investigator completed four investigators prior to training. The other two investigations were completed by staff with no training.

The ICE OPR was notified of all the allegations as documented in the investigation files. The PSA Compliance Manager/Investigator stated ICE did not complete any investigations. This could not be confirmed through the facility's investigation files. The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault; that covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the SharePoint to document compliance with the standard.

Does Not Meet (a): The facility conducts investigations with investigators that have not received specialized training for sexual abuse investigations and cross agency coordination. All facility investigators need to complete specialized training or only use the trained investigators to conduct the investigations.

Corrective Action Taken (a): The facility stated during the CAP process, "The Prison's prior practice was for specific supervisors and managers to handle and complete investigations regarding allegations of sexual abuse. These supervisors and managers were sent to

specialized training specifically to comply with PREA. On July 24, 2019, all lieutenants, unit managers, and shift commanders who were not previously trained were directed to complete the PREA Investigation of Sexual Abuse in a Confinement Setting initial module and the advanced module. All but 3 of the 46 supervisors and managers have completed the initial and advanced investigator trainings. The remaining 3 staff will complete the training." The facility provided the Specialized Investigator Training Tracing Log that documented 43 staff (lieutenants, unit managers, and shift commanders) have completed the specialized investigator training. The Auditor reviewed ten investigative files and all investigations were conducted by specialized trained investigators. The specialized training was documented through training certificates through the National Institute of Corrections (NIC) for PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations and PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations. The facility met substantial compliance.

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

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(d): The screening process for the risk of victimization and abusiveness are outlined in the facility SAAPI and Intake Processing policies. The medical and intake counselors are to screen every newly admitted detainee upon reception for any history of sexual victimization and institutional sexual predatory behavior using the prison assessment tool, YCP Screening for Victimization and Abusiveness. The criteria used to assess for sexual victimization includes mental or physical ability; age; build; first incarceration; nonviolent history; prior history for sex offenses against an adult or child; sexual orientation LGBT; prior sexual victimization; and perception of vulnerability. The additional criteria of prior acts of sexual abuse and prior convictions for violent/sexual offenses are used to assess sexual abusiveness. The screening tool is a yes or no format. If there is a yes to one of the ten questions, the detainee is offered protective custody status. If answering yes to one of the questions regarding sexual abusiveness; a supervisor's review is required within one business day of assessment. Upon entering the facility, the detainee is held in a waiting area next to the intake processing desk until intake processing is completed. Two detainees can be processed at the intake processing desk at a time. After intake processing into the facility, the detainee is escorted to IHSC for an initial medical screening. IHSC does not ask the PREA risk screening questions; however, there are targeted questions regarding sexual victimization and abusiveness. The IHSC RN stated if one of the targeted questions is confirmed, further screening questions would be asked. After the IHSC screening, the detainee is escorted to the medical intake. At medical intake, a nurse conducts the medical intake which includes general healthcare vitals and medical screening questions that include the PREA screening questions. This is conducted and maintained in the medical electronic file. The Auditor observed the process. The detainee followed through the intake and screening process had no risk factors for victimization or abusiveness. The nurse stated if the detainee scored for victimization, the electronic system would create a task for mental health. The nurse would also call mental health to inform them and the treatment manager. The task will show up on the mental health task assignment. The Classification Supervisor and Intake Staff interviewed stated if a detainee is screened at high risk of sexual victimization or a potential sexual abuse victim, mental health and the treatment manager would be called for services. They also indicated that detainees are housed in the pre-classification block until the classification process. The policy outlines once a custody level is generated it shall be provided to security staff to move the detainee to a pre-classification housing unit until the classification interview is completed. The detainees may not be moved to general population housing until a custody level, medical clearance, classification interview, and supervisor review is completed. Although the facility does not consider pre-classification housing as general population, the detainees are housed with other detainees prior to the classification process and housing determination in dorms for days up to weeks.

The staff also stated if a detainee self identifies as LGBTI, having previously experienced sexual victimization, potential aggressor, and/or expresses physical safety concerns, the detainee would meet with classification, and the PSA Compliance Manager and the Deputy Warden would be notified. Other than offering protective custody to detainees that score a yes on the risk screening tool; there are no housing determinations made to separate potential victims from potential abusers until the classification process is completed. The Inmate Classification System policy states that detainees shall be assigned a custody level within 12 hours of admission. This custody level is based on current charge or custody levels when provided via Form I-213 Record of Deportable/Inadmissible Alien. This custody level is based on security and does not take into consideration the PREA risk screening. The policy states classifications interviews should normally occur within four days. The Classification Supervisor noted this could be about 5-7 days or longer if a large group of detainees arrived. The detainees interviewed stated the classification process and housing in pre-classification housing is usually for 2-3 weeks. Of the eight detainee files reviewed, four detainees had classification; three were over a month from admission and the other one 7 days. The other four whose admissions were April 30, April 23, May 10, and unknown; their classifications had not been completed.

Does Not Meet (a): The facility does not keep detainees separate from general population until the classification process is completed and housed accordingly. The facility needs to create a process to classify the at-risk detainees for housing to ensure safety prior to being housed in pre-classification dorms or cells with other detainees or inmates.

Corrective Action Taken (a): The facility stated during the CAP that, "Detainees are evaluated by medical staff and a custody level developed within 12 hours of admission. Medical staff conducts an initial screening and assessment for risk of victimization or predatory behaviors within 12 hours of admission. This will be documented in the electronic medical record and contain the same assessment type of questions used by prison staff (York County Prison Screening for Victimization and Abusiveness Tool). The electronic medical record will need to be upgraded to include questions from the York County Prison Screening for Victimization and Abusiveness tool. This upgrade will be completed by November 30, 2019. The medical staff will complete the assessment prior to the initial housing of the detainee. Any identified risks will be forwarded to the Classification Committee (when available) or to the Zone Lieutenant to have the individual assessed for appropriate housing to either protect them or protect others until evaluated further by the Classification Committee/Program Review Committee. Detainees and inmates who enter the prison will be screened by medical staff and security staff for risk of victimization or predatory behaviors in addition to the custody level. Detainees, who are at risk of harm or are potentially predators, will be separated from the general population. Detainees deemed to be potential predators will typically be placed in an administrative housing setting until further assessment occurs. Detainees at risk of being victimized will be provided the opportunity for protective custody and reduction of custody level to a unit that allows them to feel safer. The 96-hour follow-up is where the treatment staff conduct a more in-depth interview with the detainee and inmates to determine additional treatment needs (for county inmates it typically involves risk assessments for recidivism and

the assignment of treatment plans based on Court requirements). This is also the time where the treatment team will review the custody level, ensure the TB screening is complete and read, and make any adjustments in classification based on objective information obtained since arrival. This includes the review and reassessment of potential sexual victimization or predatory behaviors." The Auditor observed the intake screening conducted by the medical staff on two detainees. The medical PREA screening does not consider the nature of the detainee's criminal history, other than if the detainee had been charged with a violent crime or a sex crime or have any current or prior convictions/charges for sexually based crimes. Even for those questions, the intake nurse is not reviewing the detainee's information and is only placing based on the response of the detainee. The intake nurses were asked how this information is assessed for potential victimization or abusiveness. They were not aware how it was determined, nor was the information shared. The Auditor interviewed the Classification Counselor who stated the medical assessments are not shared with classification counselors and classification is not aware of the questions medical asks. He further stated after the medical assessment, the detainee is housed in one of two pre-classification housing units based on custody level. The risk assessment by the classification counselors is completed the day after intake or longer. The Classification Counselor stated the risk screening tool is not a scored instrument, it is up to the judgement of the staff to determine the risk level by considering the "yes" answers. The Auditor reviewed 11 detainee files that documented the detainee was placed in pre-classification housing the day of intake. The facility is not considering the risk screening requirements when making housing decisions to ensure the safety of the detainee prior to being housed in the pre-classification dorms with other detainees and inmates. This facility does not meet the standard.

Does Not Meet (b): The initial classification and housing assignment does not occur within 12 hours of admission. The facility is conducting a risk assessment through medical within the time frame. Detainees are then housed in the pre-classification block for days to weeks prior to classification and housing determination. The facility needs to complete the initial classification and housing assignment within 12 hours of admission.

Corrective Action Taken (b): The facility stated during the CAP that, "Detainees are evaluated by medical staff and a custody level developed within 12 hours of admission. Medical staff conducts an initial screening and assessment for risk of victimization or predatory behaviors within 12 hours of admission. This will be documented in the electronic medical record and contain the same assessment type of questions used by prison staff (York County Prison Screening for Victimization and Abusiveness Tool). The 96-hour follow-up is where the treatment staff conduct a more in-depth interview with the detainee and inmates to determine additional treatment needs (for county inmates it typically involves risk assessments for recidivism and the assignment of treatment plans based on Court requirements). This is also the time where the treatment team will review the custody level, ensure the TB screening is complete and read, and make any adjustments in classification based on objective information obtained since arrival. This includes the review and reassessment of potential sexual victimization or predatory behaviors." Although the medical screening is occurring within 12 hours of intake, it does not identify detainees that are at risk for victimization or abusiveness. The Auditor interviewed the Classification Counselor who stated the risk assessment by the classification counselors is completed the day after intake or longer. The Auditor reviewed 11 detainee files: 5 detainees had the risk assessment completed by classification the following day after intake, 2 were completed 2 days after intake, 1 was completed in 3 days, and 2 were completed 4 days after intake. The facility is not completing a risk assessment to identify detainees at risk for victimization or abusiveness within 12 hours. This facility does not meet the standard.

(e) The Inmate Classification System policy states classification reviews and reassessments should occur 60 days after initial classification and then every ninety days. Classification review and reassessments should also occur for the following reasons: status change, disciplinary convictions, and supervisor direction. The reassessment is a security custody reassessment; it does not address the risk of victimization or abusiveness. When the Classification Supervisor was asked if the reassessment includes mental or physical ability; age; build; prior incarceration; nonviolent history; criminal history, and prior history for sex offenses against an adult or child; he indicated those questions except for criminal history are not asked; however, all types of questions are asked. The other questions indicated by the Classification Supervisor are not related to the requirement of the standard and are security-based questions. The reassessment is conducted using the Initial Custody Assessment Scale. Upon the Auditor's review of the reassessment tool, the tool asks about prior convictions, age, psychological impairment, mental deficiency, and physical impairment. Of the eight detainees' files reviewed, three detainees were held for a timeframe (just over sixty days) that may require a reassessment. The facility still was within the 60-90-day timeframe to complete the reassessment. The average time in custody is 60 days and with classification not occurring until about 30 days after admission; few detainees would meet the need of reclassification based on the current process. Two files were reviewed of detainees that reported sexual abuse; the Initial Custody Assessment Scale was completed; however, there was no reference to the report of sexual abuse.

Does Not Meet (e): The facility does not utilize a reassessment tool that reassesses the detainee's risk of victimization and abusiveness. The Initial Custody Assessment Scale utilized for reassessments focus on the security risk of the detainee and does not reassess the detainee's risk of victimization and abusiveness. The facility needs to create a reassessment tool that addresses the factors for accessing risk of victimization and abusiveness or utilize the YCP Screening for Victimization and Abusiveness also during the reassessment.

Corrective Action Taken (e): The facility stated during the CAP that, "The 90 day follow up is the last review and assessment for risk of victimization and predatory behaviors." The facility has developed a risk reassessment tool, YCP Follow-up Screening (60–90-day review) for Victimization and Abusiveness. This is the same risk screening tool utilized during the initial Classification risk screening. Of the 11 detainee files reviewed, 5 of the detainees were housed for a period that required a reassessment. Three of the reassessments were completed within the 60–90-day period, one was completed four months after intake, and one was not completed. The facility has not completed reassessments within the 60–90-day time frame. The Classification Counselor also stated reassessments are not completed after a reported allegation. In the review of investigative files, there were no reassessments on the detainees that reported sexual abuse. The facility does not meet the standard.

(g) Staff interviews with the PSA Compliance Manager and the Classification Supervisor confirmed appropriate controls have been implemented to ensure that sensitive information is not exploited by staff or other detainees. The records are maintained electronically in the Inmate Management System (IMS) and only staff with that level of access has accessibility to the information through a password and security code.

The information can be shared with the treatment committee and security as needed. The Auditor observed the information in the IMS, and the classification staff showed the controls needed to access the information. One random detainee interviewed stated he is used for interpretation services for detainees in the classification process. Detainees interviewed also acknowledged that other detainees were used for interpretation during the intake and classification process. Staff also acknowledged this is the practice when staff are not available to interpret. One counselor did acknowledge that he tries to use an interpretation program on the computer to communicate with a detainee that is LEP.

Does Not Meet (g): The facility is not maintaining appropriate controls on information by the use of inmate/detainee interpreters during the classification process. The facility must establish a process to controls of sensitive information and not use inmate/detainees for interpretation services.

Corrective Action Taken (g): The facility stated during the CAP, "In certain and rare circumstances, a detainee or inmate may be utilized to translate. In instances involving inmates, a Shift Commander must approve the use of an inmate to translate for another inmate. In instances involving an ICE detainee, the AFOD must be contacted for approval. This is accomplished by making a request to the Deputy Warden of Centralized Services or Deputy Warden for Security Services who will contact the AFOD for authorization. In exigent circumstances that could result in immediate harm to an inmate or detainee, the staff member may utilize an inmate or detainee interpreter. In such cases, the officer must report their decision to their supervisor verbally and in writing. If the incident involves an ICE detainee, the supervisor shall notify the Shift Commander who will coordinate a response to ICE, including the FOD." This language was added to the facility's SAAPI policy and staff were provided training during the PREA Booster Training in August 2020. The facility met substantial compliance on part of the standard with maintaining appropriate controls on information by limiting the use of inmate/detainee interpreters during the classification process.

Does Not Meet (g): Although the facilty is now maintaining sensitive detainee information from other inmates and detainee, it was discovered the facility is not maintaining appropriate controls on the dissemination within the facility of detainee sensitive information from facility staff. During the on-site visit, the Classification Counselor stated during the interview the classification risk screening tool and the reassessment is located in the YCP database that all staff have accessibility to. Staff only need to search by the detainee's name to have access to all the detainee's file information. This was confirmed through interviews with the facility's Warden and Assistant Warden. They stated the information is available to all staff in the current electronic database system and this would be addressed when the system is updated. This was also observed by the Auditor by asking a staff member to demonstrate what detainee information could be seen through the database. The facility does not meet the standard for implementing appropriate controls on the dissemination of detainee information to ensure sensitive information is not exploited to the detainee's detriment by staff.

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

(a): The facility's Inmate Classification System policy addresses the assessment process and the use of the screening information to determine housing, recreation, voluntary work, and other activities to ensure the safety of the detainee. The policy outlines once a custody level is generated, it shall be provided to security staff to move the detainee to a pre-classification housing unit until the classification interview is completed. The detainees may not be moved to general population housing until a custody level, medical clearance, classification interview, and supervisor review is completed. Recreation is conducted one housing unit at a time. The policy states all classifications levels are decided by the general makeup of the total population of the facility and new arrivals are generally classified by criminal history and current offenses when assessing available verifiable information. YCP shall assign detainees to the least restrictive housing unit consistent with facility safety and security. The PSA Compliance Manager stated assessments are based on one-on-one interviews with the detainee taking into consideration the scoring of risk of victimization and abusiveness. The counselor can override based on criminal history and observation. The Classification Supervisor reviews the classification and housing placements. The Auditors could not determine if the facility is utilizing the risk screening and classification process to make appropriate housing, recreation, and other activities to ensure the safety of the detainee. Through review of the detainee files, it appears the security custody level alone is used to determine housing placement. In one investigation file reviewed by the Auditor; it was noted that in the investigation the abuser had prior substantiated claims of abuse prior to the incident; the abuser was housed in a dorm setting. The Warden when asked stated he was not aware of that situation. The Classification Supervisor could not provide details or an explanation for the dorm housing placement.

Does Not Meet (a): The facility and policy could not demonstrate that information from the risk assessment is used to make assignments to housing other than offering a potential victim protective custody. Housing assignments are based on security custody levels. The facility needs to utilize the risk screening and classification process to determine housing other than by security custody level. If the facility is making decisions based on the risk assessment; the facility needs to document such decisions for documentation of the process.

Corrective Action Taken (a): The facility stated during the CAP that, "York County Prison Screening for Victimization and Abusiveness tool and the admission intake medical screening for risk of victimization or predatory behaviors shall be used to assist with the initial and ongoing classification of an inmate or detainee. The language in the tool has been changed to the following: If any of the above questions are answered "yes" the inmate or detainee shall be reviewed for classification to a housing unit that provides protection. The inmate/detainee shall be offered protective custody and if they decline, then housing in another location that provides improved protection shall be offered if the area can adequately protect the individual. This may include the reduction of a custody level in accordance with the Inmate Classification System." The facility also stated detainees are classified while housed in the pre-classification unit. Detainees remain in this unit until tuberculosis testing and reading is conducted. In some cases, detainees are classified to a permanent housing unit quickly, while others must wait until a housing unit appropriate to their custody level and other needs is available. Although, the process was updated, the practice does not demonstrate compliance with the changes. The intake nurses were asked how this information is assessed for potential victimization or abusiveness. They were not aware how it was determined, nor was the information shared. The Auditor interviewed the Classification

Counselor who stated the medical assessments are not shared with classification counselors and further stated after the medical assessment; the detainee is housed in one of two pre-classification housing units based solely on custody level. The facility is not considering the risk screening requirements when making housing decisions to ensure the safety of the detainee prior to being housed in the pre-classification dorms with other detainees and inmates. The Classification Counselor stated if a detainee answers certain risk assessment questions affirmatively, the detainee will be offered protective custody. He also stated that all housing is based on custody level and the criminal charges. The classification staff can override the housing placement based on their judgement. The Auditor could not determine if the risk assessment factors were considered for housing determinations upon review of the 10 of the 11 detainee files since there is no determination of risk of victimization or abusiveness; all detainees were housed in general population. The one file review was of a transgender detainee where documentation in the file demonstrated consideration was given for the safety of the detainee. The facility is still making housing placement decisions based on custody levels and not considering the risk assessment factors. This facility does not meet the standard.

§115. 43 - Protective custody

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

Notes:

(a)(b): The facility's SAAPI and Inmate Classification policies outline the protective custody placement to protect a vulnerable detainee from potential abusers until an alternative housing assignment is determined. Only a supervisor may assign and remove a detainee from administrative housing. The SAAPI policy states the alleged victim shall be offered TSPC. If the detainee refuses, the detainee should be monitored closely in general population. TSPC is used when the detainee can't be protected by other means. If the detainee is placed into TSPC, the Program Review Committee will review the placement in 72 hours and a formal hearing will be held within 5 days to determine appropriate housing. The Warden stated TSPC is used as a last resort after all other ways to protect the detainee are reviewed. First the facility would look at a dorm setting where staff provide direct supervision. The Warden also stated the TSPC assignment would not exceed 30 days unless there are extraordinary circumstances or the detainee requests to remain. An Auditor reviewed a detainee file that was placed in protective custody on request. The detainee entered protective custody on March 9th and was moved back to general population on March 20th. The policy and procedures were not developed in consultation with ICE Field Office Director (FOD).

Recommendation (a): The facility needs to have the healthcare policies reviewed and approved by the agency.

Corrective Action Taken (a): The facility's policy was approved by the ERO Philadelphia Field Office documented by memo on November 26, 2019.

Does Not Meet (a): The facility does not or did not share with the Auditors a policy that provides written procedures consistent with the subparts of the standard. The facility needs to develop written procedures or expand the SAAPI policy to address all the components of the standard and document the procedures in place.

Corrective Action Taken (a): The facility updated the 2.1 policy to state, "The use of administrative segregation, such as Temporary Secure Protective Custody, to protect detainees and inmates vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. The alleged victim or at-risk detainee/inmate shall be offered Temporary Secure Protective Custody status in accordance with the Protective Custody Policy and Procedure. If he/she refuses TSPC, the inmate or detainee should be monitored closely in general population. TSPC should only be used when the inmate or detainee cannot be protected by other means. These reasons must be documented in detail in the detention file. Staff shall explain why less restrictive housing was not appropriate and what other efforts were made to protect the detainee or inmate in a less restrictive setting. Victims and vulnerable inmates and detainees shall be housed in a supportive environment that represents the least restrictive housing option possible (e.g., in a different housing unit, transfer to another facility, medical housing, or protective custody, 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. This placement should take into account any ongoing medical or mental health needs of the victim. Victims may not be held for longer than five days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim." The PSA Compliance Manager stated the facility has not housed any detainee for protective custody for the vulnerability to sexual abuse or assault. Upon review of the investigative files, the Auditor identified three alleged victims that were placed in administrative segregation. Upon further discussion with the PSA Compliance Manager and review of the detainee detention files, the first detainee was placed in administrative segregation for a write-up for an altercation unrelated to his PREA allegation; the next detainee was placed in administrative segregation after striking the alleged perpetrator; and the last detainee was first named as an alleged perpetrator in a PREA case and then reported an allegation while in administrative segregation. A memo to the Acting Field Officer Director by the Facility Administrator states, "Since the audit ended no ICE detainees or County inmates have been placed on protective custody status due to vulnerability. York County Prison has multiple options to protect detainees and inmates from harm, which includes custody level reductions, formal separations from perpetrators of abuse, protective custody in an open general population setting, etc. Placement in secure protective custody is limited to the request by the inmate or detainee and when other options fail to adequately protect the individual. In cases where secure protective custody is utilized, it is for the shortest time possible." The facility met substantial compliance.

(d): The SAAPI policy states the Program Review Committee will review the placement in 72 hours and a formal hearing held within 5 days to determine appropriate housing for the detainee. The placement shall only continue past the five days in extraordinary circumstances. The Inmate Classification policy states the Program Review Committee will review the placement within 72 hours and then every 7 days for the first sixty days and then once a month thereafter to monitor the well-being of the detainee and make recommendations for reclassification. The Warden stated the Program Review Committee will conduct weekly reviews with the goal to get the detainee out of protective custody as soon as possible. The Program Review Committee is comprised of custody supervisor, unit manager, classification manager, licensed psychologist, and nurse. An Auditor reviewed a detainee file that was placed in protective custody on request. The detainee entered protective

custody on March 9th and was moved back to general population on March 20th. Reviews were conducted on March 12, March 13, and March 14.

Does Not Meet (d): The written policy does not meet the standard that reviews will be conducted for the first 30 days weekly and every 10 days thereafter. As mentioned in (a), the facility needs to develop written procedures or expand the SAAPI policy to address all the components of the standard and document the procedures in place.

Corrective Action Taken (d): The facility updated the 2.1 policy to state, Reviews by the Program Review Committee shall, at a minimum, conduct an identical review of the detainee or inmate within 72 hours of placement and then every week thereafter while the detainee or inmate is in administrative segregation. There were no detainees placed on protective custody in administrative segregation per the PSA Compliance Manager and memo to file by the Facility Administrator. The facility met substantial compliance.

(e): Written procedures do not address the notification to the ICE FOD no later than 72 hours after the initial placement of a detainee in protective custody on the basis of a vulnerability to sexual abuse or assault. The Warden indicated the FOD is notified at 30 days. The one detainee file reviewed, did have notification to the AFOD within 72 hours.

Does Not Meet (e): The written policy does not address the standard language. As mentioned in (a), the facility needs to develop written procedures or expand the SAAPI policy to address all the components of the standard and document the procedures in place.

Corrective Action Taken (e): The facility updated the 2.1 policy to state, "The Prison shall notify the appropriate ICE Field Office Director whenever a detainee victim or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hours. This shall be done through the use of the ICE Notification email distribution list." There were no detainees placed on protective custody in administrative segregation per the PSA Compliance Manager and memo to file by the Facility Administrator during the CAP period. The facility met substantial compliance.

§115. 52 - Grievances

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

Notes:

(e): The facility's Inmate Compliant Review System (Grievance Procedures) policy outlines that upon receipt of the grievance, the Grievance Coordinator will investigate the compliant and provide a form to all staff or other individuals mentioned in the grievance in order to report their involvement. The staff member must respond to the Grievance Coordinator within 48 hours. The Grievance Coordinator will complete a written summary with recommendations which will be forwarded to the Deputy Warden of Centralized Services with a copy to the complainant no later than ten working days after the receipt of the complaint. Although the policy states ten working days, the Grievance Coordinator stated grievances related to sexual abuse are responded to within five days. The policy states that appeals are to be replied to within 21 days by the Deputy Warden and Grievance Coordinator. There is a multi-level appeal process. A memo to file stated there were no appeals during the audit period. The one grievance was responded to within the ten-day timeframe to inform the detainee it was referred for investigation. The detainee was released prior to the outcome of the investigation on December 4th. The policy does not require that all grievances and decisions with respect to sexual abuse grievances be forwarded to the ICE FOD at the end of the grievance process. This practice could not be verified through grievance information provided to the Auditor; the grievance was a sexual harassment and not sexual abuse. The facility's definition of sexual abuse does not include sexual harassment; the DHS PREA standard includes sexual harassment within the definition of sexual abuse.

Does Not Meet (e): The facility's policy and practice of providing an outcome to the detainee within ten days is outside the standard requirement of five days. The facility does not forward grievances of sexual harassment to the ICE FOD as sexual harassment is not defined in their policy as sexual abuse. The facility must update the policy and practice to meet the timeframe of five days for a decision per the standard language. The facility should handle sexual harassment grievances the same as sexual abuse grievances as the DHS PREA includes sexual harassment as part of the definition of sexual abuse. All grievances of sexual harassment and sexual abuse need to be forwarded to the ICE FOD.

Corrective Action Taken (e): The facility updated policy 2.1 to state, "Written procedures must be implemented for identifying and handling time sensitive grievances that involve an immediate threat to detainee/inmate health, safety or welfare related to sexual abuse or assault. Decisions on grievances shall be issued within 5 days of receipt and appeals shall be responded to within 30 days. All ICE detainee grievances are forwarded to ICE FOD and AFOD via email during normal business hours. In the event a grievance is received alleging sexual assault or abuse, ICE FOD and AFOD shall be notified immediately via the ICE Notification Distribution Email. The staff member who received the grievance must notify their immediate supervisor and Shift Commander immediately to start the process of protecting the alleged victim and investigating the report." A memo to the Acting Field Officer Director stated, "Since the audit ended and the change in procedures (implementation of a 5-day grievance response time) we have not had any ICE detainees submit grievances regarding sexual abuse or assault. As a result, I am providing redacted county inmate grievance and responses to document the change in procedures and compliance with Standard 115.52. In regard to ICE notification, I have included an email notifying the FOD and other ICE staff of a verbal report of sexual abuse by an ICE detainee. This is the same method we use to notify the FOD and ICE staff of a grievance reporting an allegation of sexual abuse or assault." The Auditor reviewed the provided documentation during the CAP to review the process which demonstrated the five-day grievance response time and notification to the AFOD. The updated policy does not delineate between sexual abuse and sexual harassment; all PREA grievances are handled the same. When on-site, the PSA Compliance Manager provided a detainee grievance that alleged sexual abuse (harassment) by a staff member. The detainee was transferred from the facility prior to the response deadline. The allegation was investigated and determined unsubstantiated. The facility met substantial compliance.

§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): The facility's SAAPI policy states any county employee, visitor, contractor, volunteer, or individual who has business with the prison or uses prison resources who witnesses what appears to be the sexual abuse of a detainee or has knowledge of potential abuse must report the incident to a supervisor. The supervisor will make the appropriate notifications of the allegation to prison administration and ICE through the email distribution list. Reporting requirements are covered in the annual in-service training, basic academy, and shift briefings for all staff. Specialized and random staff interviews confirm that staff are knowledgeable in their reporting duties, the process of reporting, and to whom to report. Random staff interviewed indicated they would report immediately to their supervisor and the PSA Compliance Manager; and then write an incident report. The majority of the staff could not provide how they could report outside the chain of command; when prompted they still said they must report to their supervisor. The PSA Compliance Manager stated staff can report privately outside the chain of command by reporting to the PSA Compliance Manager and/or Deputy Warden; by contacting County Human Resources; and contacting the PSP. The policy and procedures were not reviewed and approved by ICE FOD.

Recommendation (a): The facility needs to have the facility's policy reviewed and approved by the agency and maintain documentation.

Corrective Action Taken (a): The facility's policy was approved by the ERO Philadelphia Field Office documented by memo on November 26, 2019.

Does Not Meet (a): The facility's policy does not address the requirements for staff to report retaliation against detainees or staff who reported or participated in an investigation of sexual abuse and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The facility needs to refresh staff on the methods to report an incident or misconduct outside the chain of command. The facility must expand the policy to address the language of the standard and provide training to staff on the policy changes, their requirement to report, and how to report outside the chain of command.

Corrective Action Taken (a): The facility updated 2.1 policy to state, "Any staff member, contractor or volunteer who observes or has knowledge of what appears to be the sexual abuse or assault of an inmate/detainee must report the incident immediately. Staff members, contractors and volunteers are required to report any instances of retaliation against detainees, staff, or others who either reported or participated in the investigation of an allegation of sexual abuse or harassment. This also requires the reporting of any staff, volunteer or contractor neglect or violation of responsibilities that may have contributed to the incident or retaliation. Typically, the staff member will report the incident verbally and in writing using an Officers Daily Report to their supervisor in accordance with their chain-of-command (See Organizational Chart Attachment - 6) Contractors and volunteers should report it to any staff member. However, if the volunteer, staff member or contractor does not feel comfortable following the chain-of-command because an alleged perpetrator is within that chain and/or another legitimate reason exist, they may do the following: Contact the Warden or Deputy Warden directly by email telephone call or in person; Report the incident using the third party reporting call line managed by a non-County agency; Contact ICE, OIG and ODO; Contact the Intelligence and Security Office by telephone call, in person or via email." PREA training was conducted in October/November 2019 and a PREA Booster training in August 2020 for all staff that included all the policy updates and general PREA information through lesson plan Prison Rape Elimination Act (PREA). The Auditor reviewed eight staff training files that documented the PREA training. The staff interviewed acknowledged the PREA training occurs during annual in-service. The staff interviewed stated they would report to their immediate supervisor and the PREA lieutenant. The facility met substantial compliance.

§115. 64 - Responder duties

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

(a): The facility's SAAPI policy clearly specifies the detailed procedures for security and non-security staff when responding to an allegation of sexual abuse. The first security staff member to respond to the incident is required to separate the alleged victim and abuser; immediately notify the supervisor and remain on scene until relieved by responding staff; secure the crime scene and any potential evidence; and advise the alleged victim to take no action to destroy evidence; and escort the detainee to the medical department. Through interviews with random staff, it was demonstrated that staff were knowledgeable in the steps as a first responder: to separate the alleged victim and abuser; preserve and protect the crime scene; and request the alleged victim and alleged abuser to take no action to destroy evidence; and contact a supervisor. First responder responsibilities are covered in the annual in-service training, basic academy, and shift briefings for all staff. During the review of the investigation files, it documented that staff took the appropriate steps when notified of an allegation. Of the nine closed investigations, the detainees reported allegations to staff (2), reported to medical (1), PREA hotline (1), grievance (1), ICE request slip (1), and yelled for help (1), and two incidents were observed by block officers who reported them. A staff first responder was interviewed; the staff member stated the involved detainees were separated, shift commander was notified, preserved evidence by securing the scene, and then the lieutenant took over the investigation. Of the one detainee that reported an allegation that occurred at the facility; he stated he was immediately separated and taken to medical, and the alleged abuser was taken to another area. He was also seen in mental health the same day. He was not asked about preserving evidence; the allegation was sexual harassment.

Does Not Meet (a): The facility policy does not address that staff ensure the alleged abuser does not take any action that could destroy evidence. The facility policy needs to be expanded to include the language of the standard and educate staff on the changes.

Corrective Action Taken (a): The facility updated the 2.1 policy to state, "The first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence (typically 72 hours or less), the first responder shall: Request the alleged victim not to take any actions that could destroy physical evidence, including, as

appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating; and Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. If the first responder is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy evidence." PREA training was conducted in October/November 2019 and a PREA Booster training in August 2020 for all staff that included all the policy updates and general PREA information through lesson plan Prison Rape Elimination Act (PREA). The Auditor reviewed eight staff training files that documented the PREA training. The staff interviewed acknowledged the PREA training occurs during annual in-service. Three of the staff interviewed stated they would request the detainees not take any action that would destroy evidence. All staff members, volunteers, and contractors were provided First Responder Cards to carry that covers what steps to take when an incident is reported and the facility's zero-tolerance policy. The facility met substantial compliance.

§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): The facility SAAPI policy states all allegations of sexual harassment and assault will be investigated thoroughly in order to provide prompt health intervention to those involved, prosecution or disciplinary action against the perpetrators, while being sensitive to the needs of the victim. The policy states a preliminary investigation shall be conducted by prison administration, shift commander, or assigned supervisor immediately following an allegation. The Warden indicated the facility is responsible for administrative investigations and criminal investigations would be referred to the PSP. The Investigator stated the facility has attempted to obtain investigation reports from PSP, however, PSP will only provide an outcome finding to the facility and does not provide a copy of the investigative report. The facility's SAAPI policy also states staff investigating allegations of sexual abuse or harassment have training to ensure compliance with PREA. The Investigator interviewed stated investigations are started as swiftly as possible and the investigation reports are objective as taught through training. Of the 11 allegations, 9 investigations were completed and closed; 2 were still under investigation. The allegations were referred immediately for investigation as documented in the investigation files. The investigation reports were not thorough; four were just emails with outcomes. The majority of the investigations were completed within a month. The Auditors reviewed the nine closed investigation files; six of those were conducted by investigators with no training. The one investigator completed four investigations prior to training. The other two investigations were completed by staff with no training.

Does Not Meet (a): The investigation reports were not thorough and conducted by specially trained, qualified investigators. The facility needs to complete thorough investigation reports and the investigations need to be completed by specialized trained investigators.

Corrective Action Taken (a): The facility stated during the CAP process, "The Prison's prior practice was for specific supervisors and managers to handle and complete investigations regarding allegations of sexual abuse. These supervisors and managers were sent to specialized training specifically to comply with PREA. On July 24, 2019, all lieutenants, unit managers, and shift commanders who were not previously trained were directed to complete the PREA Investigation of Sexual Abuse in a Confinement Setting initial module and the advanced module. All, but 3 of the 46 supervisors and managers have completed the initial and advanced investigator trainings. The remaining 3 staff will complete the training." The facility provided the Specialized Investigator Training Tracing Log that documented 43 staff (lieutenants, unit managers, and shift commanders) have completed the specialized investigator training. The specialized training was documented through training certificates through the National Institute of Corrections (NIC) for PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations and PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations. The Auditor reviewed ten investigative files and all investigations were conducted by specialized trained investigators and all were thorough reports addressing the requirements of the standard. The facility met substantial compliance.

(c): The standard requires the agency to develop written procedures for administrative investigations to include: preservation of direct and circumstantial evidence; interviewing alleged witnesses, victims and perpetrators; reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; assessment of the credibility of the alleged victim without regard to the individuals status as a detainee, staff, or employee and without requiring any detainee to submit to a polygraph; documentation of each investigation by written report which shall include a description of physical and testimonial evidence, the reason behind the credibility assessments, investigative facts and findings and retention of reports for as long as the abuser is detained or employed by the agency plus 5 years, such procedures shall establish the coordination and sequencing of the two types of investigations. The facility does not have written procedures for administrative investigations that address the provisions of the standard. Also, upon the Auditors review of the investigation files; the files demonstrated that the provisions of the standard are not met in the investigation reports. All investigation reports were not thorough; and four of the nine investigations were just emails with outcomes. The PSA Compliance Manager/Investigator stated the facility has started to write formal reports as of August 2018.

The Warden did indicate that investigators review during the investigative process to determine if staff followed procedures and conducted proper supervision as part of the investigation process. During the review of the investigation files, the Auditors could not determine if the investigators take staff action into consideration, since the reports were not detailed or thorough. The policy also states the Deputy Warden of Centralized Services shall retain/track all allegations of abuse, including sexual assaults and sexual harassment for a period of at least five years. The reports and information will be maintained in an electronic format in a secure file. The PSA Compliance Manager/Investigator indicated that all investigations are maintained for at least five years in hard copy, also stored electronically forever.

Does Not Meet (c): The facility does not have written procedures for administrative investigations which include the provisions of the standard. The facility needs to provide standard language in a policy that outlines the written procedures for administrative investigation provisions as outlined in the standard and documentation of an investigation report that meets the provisions of the standard.

Corrective Action Taken (c): The facility updated the 2.1 policy to state, "Administrative investigation procedures include: Preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse or assault involving the

suspected perpetrators; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, inmate, staff, or employee and without requiring any detainee or inmate who alleged sexual abuse or assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by a written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus 5 years." The Auditor reviewed ten investigative files and all the administrative investigation reports were thorough and addressed the requirements of the standard. The facility met substantial compliance.

§115. 76 - Disciplinary sanctions for staff

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

Notes:

(a)(b): The facility Employee Corrective Action outlines the disciplinary process for employees. The SAAPI policy states any staff member who sexually harasses a detainee shall be subject to discipline, revocation of security clearance, and/or criminal sanctions. The Personnel policy states any employee who violates general rules and regulations shall be subject to appropriate discipline including termination of employment. The Warden stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact detainee post until the investigation is completed. If the case was substantiated, the employee would have to go through the employee disciplinary process before termination. There was one allegation of sexual harassment by a staff member that was substantiated through investigation; however, the PREA Coordinator made the termination to overturn the outcome noting a language barrier between the staff member and detainee during the incident without a review by the Incident Review Team or discussion with the Warden. The officer was released back to normal operations with no restrictions where to work. The Auditor questioned the overturn of the outcome and the lack of any discipline of the staff member. The Auditor discussed this case with the Warden and the Warden was not aware of the case being overturned. It appears the disciplinary process was not utilized for this case. A memo to file stated there were no terminations, resignations, or other sanctions of a staff member. The agency has not reviewed and approved the policies and procedures regarding disciplinary or adverse actions for staff.

Does Not Meet (b): The facility policies do not indicate that if there is a substantiated allegation, staff removal from their position and federal service is the presumptive disciplinary sanction. The facility needs to expand the policy to include the standard provision language and have the facility's policy reviewed and approved by the agency and maintain documentation.

Correction Action Taken (b): The facility updated the 2.1 policy to state, "Staff shall be subject to disciplinary or adverse action, up to and including, removal from their position, for substantiated allegations of sexual abuse or for violating ICE or Prison sexual abuse rules, policies, or standards. Removal from their position is the presumptive disciplinary sanction for staff that have engaged in, attempted, or threatened to engage in sexual abuse, as defined in this policy and procedure." The Auditor reviewed 10 investigative files; three investigations were staff-on-detainee allegations. Separation orders were in effect during the investigations as documented in all three of these files. Two were determined unfounded and one was determined unsubstantiated. In three of the cases, staff failed to report the allegation immediately and waited hours to report. All three staff members were counseled for their actions as documented in the investigative files. The facility also provided two examples from 2018 to demonstrate practice of staff terminations for sexual abuse and not following policy operations based on the staff member's behaviors and conduct prior to and during the use of force incident where staff called the detainees sexual degrading names. The investigations determined the staff actions were unjustified and contrary to the orderly operations and reputation interest of YCP. The facility met substantial compliance.

§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:

(d): The SAAPI policy outlines the mental health counselor (MHC) will receive a copy of the disciplinary report within two days. The MHC counselor will interview the detainee to determine if there was a clear power imbalance between the involved inmates/detainees and staff. The Warden stated the detainee would be reviewed by mental health to determine if the detainee was stable to proceed with the disciplinary process. The policy does not address if the disciplinary process considers whether the detainee's mental disabilities or mental illness contributed to the detainee's behavior when determining what type of sanction, if any, should be imposed. The facility's memo to file states language is currently being amended to construct a diversionary policy, in regard to, determining disciplinary sanctions for inmates/detainees who display mental health disabilities and/or illnesses. The facility had identified the policy did not address the standard.

Does Not Meet (d): The facility's policy or practice does not address if the disciplinary process considers whether the detainee's mental disabilities or mental illness contributed to the detainee's behavior when determining what type of sanction, if any, should be imposed. The facility needs to develop a process for mental health to determine whether the detainee's mental disabilities or mental illness contributed to the detainee's behavior when determining what type of sanction, if any, should be imposed and expand policy to include the procedure.

Corrective Action Taken (d): The facility updated the 2.1 policy to state, "When a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee' s/inmate's competence to participate in the disciplinary hearing any impact the detainee's/inmate's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior. The facility shall not hold an inmate/detainee accountable for his/ her conduct if a medical authority finds him/ her mentally incompetent. For purposes of these standards, a mentally incompetent individual is defined as an individual who is unable to appreciate the difference between appropriate and inappropriate behavior, or between "right" and "wrong." Such an individual is not capable of acting in accordance with those norms and therefore, cannot be held responsible for his/ her "wrongful" actions. If a detainee has a mental disability or mental illness but is competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. A mental health professional should also be consulted as to whether certain types of sanctions, (e.g., placement in disciplinary segregation, loss of visits, or

loss of phone calls) may be inappropriate because they would interfere with supports that are a part of the detainee' s treatment or recovery plan." The mental health staff complete a Misconduct Review-Inmate Mental Status form that identifies if the detainee's mental disabilities or mental illness contributed to the detainee's behavior. There is a section of the form for the mental health staff to make recommendations. The facility provided an example where mental health determined the detainee was aware of his actions and the detainee's judgment and understanding were not impaired at the time of misconduct. The form still instructs staff to consider the detainee's mental health history and current status as a mitigating factor in determining culpability and level of discipline. The detainee was found guilty of engaging in sexual activity and sanctioned to 20 days in the Behavioral Adjustment Unit. The facility met substantial compliance.

§115. 81 - Medical and mental health assessments; history of sexual abuse

Outcome: Does not Meet Standard

Notes:

(a)(b)(c): The facility's SAAPI policy states any detainee who has a history or is a potential victim of sexual abuse shall be referred to the mental health department and Classification Committee for appropriate classification. The nurse stated if the detainee scored for victimization during the risk/health screening, the electronic system would create a task for mental health. The nurse would also call mental health to inform them and the treatment manager. The task will show up on the mental health task assignment which is checked daily by mental health. The mental health staff interviewed said the detainee is seen quickly, most times immediately. The Intake Staff interviewed stated a referral would be made as soon as the information is known. Intake staff would call mental health to inform them.

The PSA Compliance Manager stated medical, mental health, or security staff do not track the detainees who reported a history of sexual assault. The records are maintained in each detainees' independent files. A detainee list could not be provided for the Auditors to review the process for medical and mental health referrals and assessments to review for compliance. The Auditor did review a detainee file who had prior victimization; the detainee disclosed this during a random interview. Upon review of the file, the detainee was seen by mental health within 7 days of intake and was not seen by medical after the initial medical screening. The mental health case notes did not reference the referral was based on victimization or had any notes related to the PREA referral. The Auditor could not determine compliance since there were no notes referencing the referral or assessment of the detainee for the PREA referral.

Does Not Meet (b)(c): The facility could not demonstrate that detainees receive a medical evaluation within two days when a medical referral is initiated or a mental health evaluation no later than 72 hours after referral. The facility needs to develop a process to ensure medical and mental health evaluations are conducted within the appropriate time frames. Medical and mental health staff need to develop case notes referencing that the detainee has been referred for PREA to provide documentation of the process and the detainee was actually seen for the PREA referral.

Corrective Action Taken (b)(c): The facility updated the 2.1 policy to state, "If screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the inmate/detainee shall receive a health evaluation no later than two working days from the date of 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 and a medical evaluation no later than 48 hours after the referral." The health care procedure was also updated to include, "The detainee/inmate shall receive a mental health evaluation no later than 72 hours by the referral when a PREA related allegation is made and a medical evaluation no later than 48 hours by referral after a PREA related allegation is made. This shall be documented in the medical record." The facility does not maintain a list of detainees that reported previous victimization or abusiveness during the risk screening process. The Auditor asked the PSA Compliance Manager to try to obtain a list from mental health or at least five files to review. Mental health provided two files for the Auditor to review. One case was a detainee that reported a sexual assault the day before arriving; the facility handled the case as a sexual abuse report. The detainee was taken to the local hospital for a forensic exam and then was seen by medical and mental health on her return to the facility. The other file was a transgender detainee that disclosed prior sexual victimization; the detainee was seen by medical within the appropriate timeframe as documented in the mental health notes. The Auditor identified two detainees through reviewing the intake risk screening: one that disclosed prior victimization and the other who disclosed prior abusiveness (charge of rape). Neither detainee was referred or seen by mental health for the victimization or abusiveness. During the facility tour, the Auditor interviewed a mental health staff member that stated if a detainee disclosed prior sexual victimization or abusiveness, the detainee would be told to submit a sick call slip to be seen by mental health. The Auditor observed on intake during which the detainee disclosed prior victimization. The following day, the Auditor requested to see the referral to mental health; a referral was not made. The Classification Counselor stated in his interview that if a detainee discloses prior victimization, a referral is not made since everyone sees mental health. He shared that 8 out of 10 female detainees disclose prior victimization. The facility could not demonstrate that detainees receive a medical or mental health evaluation within two days when a medical referral is initiated or a mental health evaluation no later than 72 hours after referral. The staff stated referrals are not made for victimization or abusiveness as the Auditor observed during the intake process. The facility does not meet the standard.

§115. 86 - Sexual abuse incident reviews

Outcome: Does not Meet Standard

Notes:

(a)(b): The facility's SAAPI policy states the Deputy Warden of Centralized Services in conjunction with other prison administrators shall review all reports of sexual assault/abuse and ensure that appropriate administrative follow-up is completed. The review is documented on the Sexual Abuse or Assault Incident Review- Plan of Action Form. The form reviews the incident details, notifications, criminal investigation details, administrative investigation details, group dynamics (including race, ethnicity, gender identity, lesbian, gay, bisexual, transgender; intersex identification, status, or perceived status; or gang affiliation), staffing, physical plant, incident response, and policy and practice. There is also a recommendation page that lists recommendations and the method of implementation. The form has signatures for the lead reviewer (usually the PSA Compliance Manager) and PREA Coordinator. The Warden stated sexual abuse incident reviews are conducted utilizing the checklist

and all the factors are considered that are relevant for the case. The PSA Compliance Manager stated the initial review is completed by the PSA Compliance Manager and then the Deputy Warden of Centralized Services/PREA Compliance Manager. She also stated only one person is involved in the reviews, and that is the individual who signs the bottom of the Sexual Abuse or Assault Incident Review- Plan of Action Form. The Auditors reviewed the nine closed investigation files for incident reviews; three files did not have incident reviews, four were completed after the 30-day requirement (8 months, 2 months, 4 months, and 2 months), and two were completed within the 30-day requirement. The incident reviews were not conducted by a review team; one staff member made the review, either the PREA Coordinator or the PSA Compliance Manager. The forms were not completed fully and three were not signed off by a Lead reviewer, PREA Coordinator, or the PSA Compliance Manager; a determination of who completed the review was not possible. Two reports noted recommendations, but there was no documentation the recommendations were implemented, or recommendations were forwarded for action. The Auditors could not determine if the reports were forwarded to the agency's PSA Coordinator. The investigator substantiated a case of staff-on-detainee sexual harassment; however, the PREA Coordinator overturned the outcome noting a language barrier between the detainee and staff member during the incident. The officer was released back to normal operations with no restrictions where to work. The incident review should have been conducted by the Incident Review Team. The Incident Review Team could have completed a thorough review that confirmed or overturned the decision. There may have been further recommendations regarding staff actions and staff training on communicating with a LEP detainee.

Does Not Meet (a)(b): The facility does not complete the reviews by a team, complete the review form completely to address all the components of review, and the reviews are not completed within 30 days or not at all. The facility needs to complete the incident reviews by a review team considering and documenting all components of the standard are reviewed within the 30-day requirement. The facility must forward the review to the agency's PSA Coordinator.

Corrective Action Taken (a)(b): The facility updated the 2.1 policy to state, "The Prison shall conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For any substantiated or unsubstantiated allegation, the facility shall prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and assault. The PREA Manager along with a multi-disciplinary team of staff (Health Services Administrator, licensed professional counselor, security supervisor, Warden, Deputy Wardens, and other supervisory staff deemed appropriate based on the specifics of the allegation or incident) shall complete Attachment – 2 (Sexual Abuse or Assault Incident Review Plan of Action Form). The Program Review Committee (PRC) shall be the primary multi-disciplinary team to review and make recommendations for 30-day sexual abuse and assault allegations. Copies of Attachment - 2 shall be forwarded to the Field Office Director through the Assistant Field Office Director onsite." Of the 10 investigative files reviewed, 9 had completed Sexual Abuse Incident Reviews completes. Eight of the reviews were completed within 30 days. Seven of the incident reviews were completed by the Program Review Committee. The facility met substantial compliance.

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.

Barbara King August 26, 2021

Auditor's and Program Manager's Signature & Date

(b) (6), (b) (7)(C) August 26, 2021

Assistant Program Manager's Signature & Date