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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	New Orleans		
Field Office Director:	Mellissa Harper		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1250 Poydras Street, Suite 325 New Orleans, LA 70113		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Alexandria Staging Facility		
Physical address:	96 George Thompson Drive, Alexandria, Louisiana 71303		
Telephone number:	318-483-1600		
Facility type:	Staging Facility		
PREA Incorporation Date:	6/19/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	318-910-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	318-922-(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.

During the audit, the Auditor found Alexandria Staging Facility met 24 standards, had 2 standards that exceeded, had 2 standards that was non-applicable, and had 13 non-compliant standards. As a result of the facility being out of compliance with 13 standards, the facility entered a 180-day corrective action period which began on December 27, 2023, and ended on June 24, 2024. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Initially Not Met: 13

- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.
- §115.17 - Hiring and promotion decisions.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.51 - Detainee reporting.
- §115.61 - Staff reporting duties.
- §115.65 - Coordinated response.
- §115.67 - Agency protection against retaliation.
- §115.71 - Criminal and administrative investigations.
- §115.72 - Evidentiary standard for administrative investigations.
- §115.78 - Disciplinary sanctions for detainees.
- §115.81 - Medical and mental health assessments; history of sexual abuse.

Number of Standards Exceeded: 0

Number of Standards Met: 12

- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.
- §115.17 - Hiring and promotion decisions.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.51 - Detainee reporting.
- §115.61 - Staff reporting duties.
- §115.65 - Coordinated response.
- §115.67 - Agency protection against retaliation.
- §115.71 - Criminal and administrative investigations.
- §115.72 - Evidentiary standard for administrative investigations.
- §115.78 - Disciplinary sanctions for detainees.

Number of Standards Not Met: 1

- §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.

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

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

Notes:

(a)(b): ASF policy 10.1.1 states, "ASF shall ensure that Detainees with disabilities (i.e., those who are deaf, hard of hearing, blind, have low vision, intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from the Company's efforts to prevent, detect, and respond to Sexual Abuse and Assault. ASF shall provide written materials to every Detainee in formats or through methods that ensure effective communication with Detainees with disabilities, including those who have intellectual disabilities, limited reading skills or who are blind or have low vision. Methods to ensure effective communication shall include, when necessary, access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation." During the on-site audit, the Auditor observed the facility PREA video available in English, Spanish and closed captioning, for the deaf or hard or hearing detainees. During the on-site audit the Auditor further observed the facility had the capabilities to print a transcription of the video, and translate it into other languages, if needed. Interviews with two Processing Officers, indicated during Intake processing, the detainees watch the video, are provided the facility local supplement handbook and if a detainee spoke a language other than English or Spanish, the "forms", (which include the Orientation Sign-In Sheet and the PREA Risk Assessment, which do not contain PREA information, such as zero-tolerance or how to report an allegation of sexual abuse), would be read to them with the use of the facility language line. The Auditor reviewed the facility's September 2023 Language line bill and confirmed, the language line had been utilized 445 times, during intake; however, the two Processing Officers could not articulate how PREA education would be provided to detainees who are LEP, deaf or hard of hearing (other than information available in the PREA video, blind or have low vision, or who have intellectual, psychiatric, or speech disabilities. During the on-site audit, the Auditor did not observe a supply of the ICE National Detainee Handbook in Intake process, available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese; however, the Auditor observed an English and Spanish version of the ICE National Detainee Handbook posted in each housing unit. In addition, during the on-site audit, the Auditor did not observe copies of the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet available in 15 most prevalent languages encountered by ICE, Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian; however, PREA information, to include the DHS-prescribed sexual assault awareness notice, the instructions and contact information for OIG, DRIL, and RAINN, available in English and Spanish only, was observed posted in all housing units. Interviews with 23 detainees, could not confirm, the detainees were provided access to PREA related information through in-person, telephonic, or video interpretive services that enabled effective, accurate and impartial interpretation. In addition, based on observation during the on-site audit, the Auditor could not confirm all written material related to sexual abuse was available in a format or through methods all detainees could understand to include detainees, who might be LEP, deaf or hard of hearing, blind or have low vision, or who have intellectual, psychiatric, or speech disabilities.

(c): ASF policy 10.1.1 states, "In matters relating to Sexual Abuse, ASF shall provide in-person or telephonic interpretation services that enable effective, accurate and impartial interpretation, by someone other than another Detainee, unless the Detainee expresses a preference for a Detainee interpreter and the Facility determines that such interpretation is appropriate. Minors, alleged abusers, Detainees who witnessed the alleged abuse, and Detainees who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of Sexual Abuse." The Auditor reviewed the Sexual Abuse and Assault Prevention and Intervention (PREA) 2017 In-Service training curriculum and confirmed the staff training mirrors the facility policy. Interviews with three random DOs, confirmed they would not utilize a detainee for interpretation unless requested by the detainee and approved by the supervisor. An interview with the facility PSA Compliance Manger/Investigator confirmed if the detainee requested another detainee to provide interpretation during an investigation into an allegation of sexual abuse the request and who provided the interpretation would be documented in the investigative report.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit the Auditor reviewed the facility's September 2023 Language line bill and confirmed, the language line had been utilized 445 times to translate the Intake Orientation Sign-In Sheet and the PREA Risk Assessment; however, the two Processing Officers could not articulate how PREA education would be provided to detainees who are LEP, deaf or hard of hearing, with the exception of the information provided in the PREA video, blind or have low vision, or who have intellectual, psychiatric, or speech disabilities. During the on-site audit, the Auditor did not observe a supply of the ICE National Detainee Handbook in Intake processing, available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. In addition, during the on-site audit, the Auditor did not observe in Intake processing copies of the DHS-prescribed SAA Information pamphlet available in 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian. Interviews with 23 detainees, could not confirm, the detainees were provided access to PREA education through in-person, telephonic, or video interpretive services to enable effective, accurate, and impartial interpretation. In addition, the Auditor could not confirm all written material related to sexual abuse was available in a format or through methods all detainees could understand to include detainees, who might be LEP, deaf or hard of hearing, blind or have low vision, or who have intellectual, psychiatric, or speech disabilities. To become compliant, the facility must implement a practice that ensures all detainees have an equal opportunity to participate or benefit from all aspects of both the Agency and facility efforts to prevent, detect, and respond to sexual abuse to include the information available in the ICE National Detainee Handbook, the facility Supplemental to the National Detainee Handbook, DHS-prescribed SAA information pamphlet and any other PREA related information the facility makes available to detainees. Once implemented, the facility must submit documentation that confirms all Processing Officers have received training on the implemented practice. In addition, the facility must submit 15 detainee files, to include if applicable, detainees whose preferred language is other than English or Spanish, who are deaf or hard of hearing, who are blind or have low vision, who have intellectual, psychiatric, or speech disabilities, or have limited reading skills that occur during the Corrective Action Plan (CAP) period to confirm all detainees have an equal opportunity to participate or benefit from all aspects of both the Agency and facility efforts to prevent, detect, and respond to sexual abuse to include the information available in the ICE National Detainee Handbook, the facility Supplemental to the National Detainee Handbook, DHS-prescribed SAA information pamphlet and any other PREA related information the facility makes available to detainees.

Corrective Action Taken:

The facility submitted a memorandum to all staff. The Auditor reviewed the memorandum and confirmed the memorandum requires during the intake process staff provide detainees a copy of the ICE National Detainee

Handbook, available in 15 languages, the Supplemental to the National Detainee Handbook, available in English and Spanish and the SAA information pamphlet, available in 15 languages, to include K'iche' (Quiche')/Kxlantzij and to acknowledge the receipt of the handbooks and the pamphlet on the orientation sign-in sheet. A review of the submitted memorandum further confirms staff are instructed if a detainee is deaf or hard of hearing staff will provide the information with the use of the translation line with the phone amplified or by sign language utilizing video relay service (VRS) and detainees who are blind or have low vision can use magnifier optic devices to read the material or a staff member or translation service can read the information to them. In addition, a review of the memorandum confirms the memorandum instructs staff, if needed, where to locate the handbooks, pamphlets, and the specific devices. The facility submitted sign-in sheets which confirmed staff have read the memorandum. The facility submitted 10 detainee files to include detainees whose preferred language is other than English and Spanish. The Auditor reviewed the detainee files and confirmed detainees whose preferred language is other than English and Spanish received orientation, to include the ICE National Detainee Handbook, the facility Supplemental to the National Detainee Handbook, and the DHS-prescribed SAA information pamphlet by utilizing the language line to provide the PREA related information to the detainee. The facility submitted a memo to Auditor which states, "There have been no detainees received during the CAP period who were deaf or hard of hearing, who are blind or have low vision, who have intellectual, psychiatric, or speech disabilities, or have limited reading skills." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. ASF policy 10.1.1 states, "ASF is prohibited from hiring or promoting anyone (who will have direct contact with Detainees) who has engaged in Sexual Abuse in a prison, jail, holding Facility, community confinement Facility, Juvenile Facility or other institution who has been convicted of engaging in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. ASF shall conduct a background investigation to determine whether the candidate for hire is suitable for employment, including a criminal background record check and make its best efforts to contact prior institutional employers to obtain information on substantiated allegations of Sexual Abuse or any resignation pending investigation of an allegation of Sexual Abuse, prior to hiring new Employees. Background investigations, including criminal background records checks shall be repeated for all Employees at least every five years. Upon request, ASF shall submit written documentation showing the detailed elements of the Facility's background check for each Employee and the Facility's conclusions. ASF shall also impose upon Employees a continuing affirmative duty to disclose any such conduct as part of its hiring and promotional

processes, and during annual performance reviews for current Employees. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate. Unless prohibited by law, ASF shall provide information on substantiated allegations of Sexual Abuse involving a former Employee upon receiving a request from an institutional employer for whom such Employee has applied to work." An interview with the HMR indicated before hiring a potential employee they must complete the Electronic Questionnaire for Investigation Processing (e-QIP) and must provide fingerprints. The HRM further indicated background checks are completed by the ICE Personnel Security Unit (PSU) and ICE determines suitability for hiring. In addition, the HRM indicated potential employees will fill out a Declaration for Federal Employment which states, "All your answers must be truthful and complete. A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you or for firing you after you begin work" and all potential staff and volunteers are required to complete the DHS 6 Code of Federal Regulations Part 115 which asks potential staff/contractors all questions required by subsection (a) of the standard. The form requires the participant to sign the form which includes "I understand that a knowing and willful false response may result in a negative finding regarding my fitness as a contract employee supporting ICE. Furthermore, should my answers change at any time I understand I am responsible for immediately reporting the information to my Program Manager." An interview with the HRM further indicated the facility provides information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Utilizing the PSU Background Investigation for Employees and Contractors, the Auditor submitted 22 names to include 6 ICE staff, 5 IHSC medical staff, and 11 ASF staff to confirm background investigations. Documentation was provided to confirm all submitted names had completed a background check, had completed all required forms prior to being hired, and all five-year background checks had been completed as required. The Auditor reviewed two volunteer files and confirmed a background check had been completed and the volunteers had been asked about the prohibited behaviors prior to beginning services at that the facility. In an interview with the HRM it was indicated no ASF staff had been promoted during the reporting period. However, an interview with the DFOD indicated one staff member had been promoted to a SDDO during the reporting period. An interview with the promoted SDDO confirmed he had not been asked about previous sexual misconduct in an interview of written application prior to his promotion. An interview with the facility PSA Compliance Manager, indicated the facility does not utilize the services of contractors.

Recommendation: The Auditor recommends the facility revise ASF 10.1.1 to include the facility will not enlist the services of volunteers who may have contact with detainees who has engaged in the behaviors prohibited by subsection (a) of the standard.

Corrective Action:

The Agency is not in compliance with subsections (a) and (b) of the standard. An interview with the DFOD indicated one staff member had been promoted to a SDDO during the reporting period. An interview with the SDDO confirmed he had not been asked about previous sexual misconduct in an interview or written application prior to his promotion. To become compliant the Agency must develop a process which requires employees offered promotions are directly asked about previous sexual misconduct related to sexual abuse in an interview or through a written application prior to being promoted as required by subsections (a) and (b) of the standard. In addition, if applicable, the Agency must provide the Auditor with documentation to confirm any ICE staff promoted during the CAP period was asked directly about previous misconduct related to sexual abuse either in an interview or by written application prior to being promoted.

Corrective Action Taken:

The facility submitted a memorandum to the Auditor from the Agency PSAC. The Auditor reviewed the memorandum and confirmed beginning October 23, 2023, the Agency has implemented a practice which requires ICE Employees being considered for promotion are asked about previous misconduct prior to the promotion. In

addition, the facility submitted a completed DHS 6 Code of Federal Regulations Part 115 form which confirmed the SDDO promoted during the audit period was asked post audit about previous sexual misconduct. As the facility cannot come into compliance based on practice implemented after the audit period, the Auditor accepts the memorandum from the Agency PSAC for confirmation of compliance with subsections (a) and (b) of the standard.

§115.33 - Detainee education.

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

Notes:

(a)(b)(c)(f): ASF policy 10.1.1 states, "During the intake process, ASF shall ensure that the Detainee orientation program notifies and informs Detainees about the Company's zero tolerance policy regarding all forms of Sexual Abuse and Assault and includes instruction on: 1) Prevention and intervention strategies; 2) Definitions and examples of Detainee-on-Detainee Sexual Abuse, Employee on Detainee Sexual Abuse and coercive Sexual Activity; 3) Explanation of methods for reporting Sexual Abuse, including to any Employee, including an Employee other than immediate point-of contact line officer (i.e. the PSA Compliance Manager or Mental Health staff), the DHS Office of Inspector General, and the Joint Intake Center; 4) Information about self-protection and indicators of Sexual Abuse; 5) Prohibition against retaliation, including an explanation that reporting Sexual Abuse shall not negatively impact the Detainee's immigration proceedings; and, 6) The right of a Detainee who has been subjected to Sexual Abuse to receive treatment and counseling. At ASF, education shall be provided in formats accessible to all Detainees, including those are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to Detainees who have limited reading skills. ASF shall maintain documentation of Detainee participation in the intake process orientation which shall be retained in their individual files." During the on-site audit, the Auditor reviewed the ICE National Detainee Handbook and confirmed the ICE National Detainee Handbook includes information on how to report an allegation of sexual abuse. In addition, during the on-site audit, the Auditor observed the ICE National Detainee Handbook, posted in English and Spanish, in each housing unit; however, the Auditor did not observe the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, or copies of the DHS-prescribed SAA Information pamphlet available in 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian in Intake processing. In addition, during the on-site audit, the Auditor partially observed the orientation process due to the detainee's late arrival and confirmed once the detainees had their bed assignments, they were instructed to sit in the common area of the housing unit and watch the PREA orientation video available in English, Spanish, and closed captioning, for detainees who were deaf or hard of hearing. However, in an interview with two Processing Officers it was confirmed the facility had the capability to print a transcription of the video, and translate it into other languages, if needed. Interviews with two Processing Officers, indicated during Intake processing, the detainees watch the video, are provided the facility local supplement handbook, and the detainees are asked to sign the facility Orientation Sign-In Sheet, confirming receipt of the video and the handbook. The Auditor reviewed the Orientation Sign-in Sheet, available in English and Spanish and confirmed the sign-in sheet states, "I have reviewed the Orientation Video and the PREA-What You Need to Know video and I have been given the opportunity to ask questions. I have received the local supplement Resident Handbook and I understand the policies and procedures of the Alexandria Staging Facility. I have been advised the Orientation/Education Station is accessible in the housing unit which contains the ICE National Detainee Handbook and additional SAAPI information. I have been given the ICE Sexual Abuse and Assault Awareness pamphlet in my preferred language. I have been given instructions on how to use the telephone and I understand the first call is provided to me as a courtesy." In addition, the Auditor reviewed the facility PREA Risk Assessment and confirmed it includes "Receipt of DHS Pamphlet" and requires the detainee signature. During interviews with two Processing Officers, it was indicated if a detainee spoke a

language other than English or Spanish, the forms would be read to them with the use of the facility language line. The Auditor reviewed the facility's September 2023 Language line bill and confirmed the language line had been utilized 445 times during Intake processing: however, an interview with two Processing Officers confirmed the two Processing Officers could not produce the DHS-prescribed SAA Information pamphlet and could only produce a copy of the ICE National Detainee Handbook in English only; and therefore, the Auditor could not confirm the language line was utilize to provide the detainee PREA orientation. The Auditor interviewed 23 detainees to include 5 detainees who had gone through the intake process the evening prior to the interview and each detainee had been given the opportunity to watch the PREA video; however, after having traveled all day, they were too exhausted; and therefore, did not watch the video. Interviews with five detainees who had gone through the intake process the night before further confirmed they had not been given any written material to include the facility handbook, the ICE National Detainee Handbook, or the DHS-prescribed SAA Information pamphlet; and therefore, the Auditor had each detainee, review their signed PREA Risk Assessment and the signed Orientation Sign-In Sheet, and inquired why the five detainees had signed the documents if they had not received the PREA information. Each detainee processed the night before the interview confirmed the Processing Officer had instructed them to sign in three separate places and they followed the officer's direction even though they were not given an opportunity to read the document. In addition, each detainee interviewed who was processed the evening prior to the interview confirmed they did not read the PREA Risk Assessment and when shown the document, which indicated they had received the DHS SAAPI Pamphlet, they each confirmed they thought they were signing an acknowledgement that they had completed the assessment and not that they had received written material. In interviews with the additional 18 detainees, it was indicated they were not given any written documentation, during Intake process; however, several detainees reported immediately prior to the Auditor's interview, the housing unit officers had yelled out, asking if anyone wanted a copy of the facility handbook. The Auditor reviewed 18 detainee files and confirmed all detainees had signed the PREA Risk Assessment and the Orientation Sign-In Sheet; however, based on detainee interviews and Auditor observation during the orientation process the Auditor could not confirm what PREA orientation, if any, was provided to the detainees during the intake process.

(d)(e): ASF policy 10.1.1 states, "ASF shall post on all housing unit bulletin boards the following notices: 1) The DHS-prescribed sexual assault awareness notice; 2) The name of the PSA Compliance Manager; and 3) The name of local organizations that can assist Detainees who have been victims of Sexual Abuse. Facilities shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet. Detainee notification, orientation and instruction must be in a language or manner that the detainee understands. The facility shall maintain documentation of detainee participation in the instruction session. The information is communicated orally and in writing, in a language clearly understood by the detainee, upon arrival at the facility." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, which contained the name of the facility PSA Compliance Manager, and a flyer RAINN, which operates the National Sexual Assault Hotline, posted in all housing units. However, the Auditor could not confirm the DHS-prescribed SAA Information pamphlet is available or distributed to the detainees during the intake process. In addition, interviews with two Processing Officers and 23 detainees confirmed neither the officers or the detainees were aware of the DHS-prescribed SAA Information pamphlet or the information it contained.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed the ICE National Detainee Handbook, posted in English and Spanish in each housing unit; however, the Auditor did not observe the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, or copies of the DHS-prescribed SAA Information pamphlet available in 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish,

Vietnamese, Turkish, and Ukrainian in Intake processing. The Auditor reviewed the facility's September 2023 Language line bill and confirmed, the language line had been utilized 445 times during intake; however, while in the Processing office, the Auditor requested each Processing Officer, to show her the DHS-prescribed SAA Information pamphlets and the ICE National Detainee Handbooks and the two Processing Officers could not produce the DHS-Prescribed SAA Information pamphlet and could only locate a copy of the ICE National Detainee Handbook in English. The Auditor interviewed five detainees who had been process the evening before the interview and confirmed each detainee had been given the opportunity to watch the PREA video; however, after having traveled all day, they were too exhausted; and therefore, did not watch the video. Interviews with five detainees who had gone through the intake process the night before further confirmed they had not been given any written material to include the facility handbook, the ICE National Detainee Handbook, or the DHS-prescribed SAA Information pamphlet; and therefore, the Auditor had each detainee, review their signed PREA Risk Assessment and the signed Orientation Sign-In Sheet, and inquired why the five detainees had signed the documents if they had not received the PREA information. In addition, in an interview with five detainees processed the night before the interview confirmed the Processing Officer had instructed them to sign in three separate places and they followed the officer's direction even though they were not given an opportunity to read the document. In an interview with five detainees processed the night before the interview confirmed they did not read the PREA Risk Assessment and when shown the document, which indicated they had received the DHS-prescribed SAA Information Pamphlet, they each confirmed they thought they were signing an acknowledgement confirming they had completed the assessment and not that they had received written material. In interviews with an additional 18 detainees, it was indicated they were not given any written documentation, during Intake process; however, several detainees reported immediately prior to the Auditor's interview, the housing unit officers had yelled out, asking if anyone wanted a copy of the facility handbook. The Auditor reviewed 18 detainee files and confirmed all detainees had signed the PREA Risk Assessment and the Orientation Sign-In Sheet; however, based on detainee interviews and Auditor observation during the orientation process the Auditor could not confirm what PREA orientation, if any, was provided to the detainees during the intake process. To become complaint, the facility must implement an orientation program during the intake process which notifies and informs the detainee about the Agency and the facility zero-tolerance policies and includes instructions on all elements required by subsection (a) of the standard. The orientation program shall include notification, orientation, and instruction in formats accessible to all detainees, including those who are LEP, deaf or hard of hearing, blind or have limited site or otherwise disabled, as well as those who have limited reading skills. Once the orientation program has been implemented the facility must submit documentation which confirms all Processing Officers have received training on the updated practice. In addition, the facility must submit 15 detainee files to include, if applicable detainees whose preferred language is other than English or Spanish and/or are deaf or hard of hearing, blind or have limited site or otherwise disabled, as well as those who have limited reading skills during the CAP period. The facility is not in compliance with subsection (e) of the standard. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, which contained the name of the facility PSA Compliance Manager and a flyer for RAINN, which operates the National Sexual Assault Hotline, posted in all housing units. However, the Auditor could not confirm that the DHS-prescribed SAA Information pamphlet is available or distributed to the detainees as required by subsection (e) of the standard. In addition, interviews with two Processing Officers and 23 detainees confirmed neither were aware of the DHS-prescribed SAA Information pamphlet or the information it contained. To become complaint, the facility must submit documentation which confirms the DHS-prescribed SAA Information pamphlet available in the 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian is distributed to all detainees during intake processing in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all Processing Officers have received training on the updated practice. In addition, the facility must submit 15 detainee files to include, if applicable detainees whose preferred language is other than English or Spanish and/or are deaf or hard of hearing, blind or have limited site or otherwise disabled, as well as those who

have limited reading skills to confirm the detainee has received the DHS-prescribed SAA Information pamphlet in a manner they can understand during the CAP period.

Corrective Action Taken:

(a)(b): The facility submitted a memorandum to all staff. The Auditor reviewed the memorandum and confirmed the memorandum requires staff, during the intake process, to provide detainees a copy of the ICE National Detainee Handbook, available in 15 languages, the Supplemental to the National Detainee Handbook, available in English and Spanish and the SAA information pamphlet, available in 15 languages, to include K'iche' (Quiche')/Kxlantzij and to acknowledge the receipt of the handbooks and the pamphlet on the orientation sign-in sheet. A review of the submitted memorandum further confirms staff are instructed if a detainee is deaf or hard of hearing staff will provide the information with the use of the translation line with the phone amplified or by sign language utilizing video relay service (VRS) and detainees who are blind or have low vision can use magnifier optic devices to read the material or a staff member or translation service can read the information to them. In addition, a review of the memorandum confirms the memorandum instructs staff, if needed, where to locate the handbooks, pamphlets, and the specific devices. The facility submitted sign-in sheets which confirmed staff have read the memorandum. The facility submitted 10 detainee files to include detainees whose preferred language is other than English and Spanish. The Auditor reviewed the detainee files and confirmed detainees whose preferred language is other than English and Spanish received orientation, to include the ICE National Detainee Handbook, the facility Supplemental to the National Detainee Handbook, and the DHS-prescribed SAA information pamphlet by utilizing the language line to provide the PREA related information to the detainee. The facility submitted a memo to Auditor which states, "There have been no detainees received during the CAP period who were deaf or hard of hearing, who are blind or have low vision, who have intellectual, psychiatric, or speech disabilities, or have limited reading skills." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

(e): The facility submitted a revised Post Order Intake/Processing Officer and a revised Post Order Intake Supervisor. The Auditor reviewed the revised post orders and confirmed the post orders include "During the intake process, processing officers will provide all incoming detainees with a copy of the ICE National Detainee Handbook in 14 languages, the facility Supplemental to the National Detainee handbook in English and Spanish, and a DHS-prescribed SAA information pamphlet in 15 languages and processing officers and detainees will document the receipt of these items by signing the orientation sign-in sheet. A review of the revised post orders further confirmed the post orders include, "Detainees who are dear or hard of hearing can receive the information via translation services. Detainees who are blind or have low vision can use magnifier optic devices to read the materials or a staff member and/or translator service can read the information to them, and all handbooks and pamphlets are available in electronic format on the facility common drive." In addition, the facility submitted an email sent to all ASF staff, with read receipts, which included the same verbiage as the post orders. The facility submitted an email discontinuing the PREA video as part of the orientation program at the facility; and therefore, the Auditor no longer requires documentation to confirm detainees are provided the PREA information included in the PREA video in a manner all detainees can understand. The facility submitted 10 detainee files. The Auditor reviewed the submitted detainee files and confirmed LEP detainees received the information in the DHS-prescribed SAA information pamphlet by utilizing the language line to provide the PREA related information to the detainee. The facility submitted a memo to Auditor which states, "There have been no detainees received during the CAP period who were deaf or hard of hearing, who are blind or have low vision, who have intellectual, psychiatric, or speech disabilities, or have limited reading skills." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (e) of the standard.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d)(g): ASF policy 10.1.1 states, "All Detainees shall be assessed during intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house Detainees to prevent Sexual Abuse, taking necessary steps to mitigate any such danger. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly. The initial classification process and initial housing assignment shall be completed within 12 hours of admission to the Facility. ASF shall also consider, to the extent that the information is available, the following criteria to assess Detainees for risk of sexual victimization to be completed by Officers: 1) Mental, physical or developmental disability; 2) Age; 3) Physical build and appearance; 4) Previous incarceration or detained; 5) Nature of criminal history; 6) Prior convictions for sex offenses against an adult or child; 7) Whether Detainee self-identified as LGBTI or Gender Nonconforming; 8) Whether Detainee self-identified as having previously experienced sexual victimization; and, 9) Own concerns about his/her physical safety. e. The intake screening shall also consider prior acts of Sexual Abuse, prior convictions for violent offenses, and history of prior institutional violence or Sexual Abuse, as known to the Facility, in assessing the risk of being sexually abusive." The Auditor reviewed the PREA Risk Assessment tool and confirmed it includes all elements required by subsections (c) and (d) of the standard. During the on-site audit, the Auditor partially observed the intake process and confirmed the housing unit assignment of each detainee was already known by observing detainees classified as high-level being lined up outside the high-level housing unit and then instructed to enter the unit and find themselves a cell with an empty bed. While in the housing unit the Auditor informally interviewed several detainees who confirmed they had to pick a bed which already had one detainee in the cell. In interviews with two Processing Officers, it was indicated detainees are taken into the Processing Officer's office located inside the housing unit which is shared with medical staff divided halfway with a partition. Interviews with two Processing Officers further indicated detainees are asked the questions on the initial risk assessment while medical staff are conducting their initial assessment of other detainees and if a detainee discloses, he has experienced sexual abuse or has been sexually abusive the processing officer will notify the Intake supervisor who will come and sign the assessment. The Auditor interviewed 23 detainees to include 5 detainees who had gone through the intake process the evening prior to the interviews and confirmed the 5 detainees who were processed the evening prior to the interview had been asked the initial risk assessment questions on the initial risk assessment; however, two of the detainees indicated they had been woken up in the middle of the night to answer the questions and the remaining three detainees confirmed they had been asked the initial risk assessment questions just prior to the Auditor's visit to the unit the following morning. During the on-site Audit the Auditor observed the facility maintained the completed risk assessments in a locked cabinet located in the Intake Supervisor's office; however, interviews with the remaining 18 detainees confirmed although they were asked the initial risk assessment questions, they had lied in answering them as there were other detainees in the room completing medical assessment and they did not want the other detainees to know their sexual preference or if they had experienced sexual abuse, so they indicated "no" when asked. Based on this information, the Auditor could not confirm the facility has implemented appropriate controls on the dissemination of responses to the initial risk assessment to ensure sensitive information provided is not exploited to the detainees' detriment by other detainees. Two of the detainees shared with the Auditor they were gay and had previously experienced sexual abuse within their lifetime which the Auditor promptly reported to facility administration. The Auditor reviewed 18 detainee files and confirmed an assessment had been completed; however, the Auditor could not confirm the initial risk assessment was being utilized to determine a detainee's risk of victimization or risk of being sexually abusive. During the on-site Audit the Auditor confirmed the facility has implemented appropriate controls on the dissemination of responses to the initial risk assessment by maintaining the completed risk assessments in a locked cabinet located in the Intake Supervisor's office.

(e)(f): ASF policy 10.1.1 states, "ASF shall ensure that between 60 and 90 days from the initial assessment at the

Facility, staff shall reassess each Detainee's risk for victimization or abusiveness using the PREA Vulnerability Reassessment Questionnaire which is to be completed by Case Managers. The PREA Risk Assessment form is completed initially upon arrival. At any point after the initial intake screening, a Detainee shall be reassessed for risk of victimization or abusiveness when warranted based upon the receipt of additional, relevant information or following an incident or abuse or victimization. Disciplining Detainees for refusing to answer or not providing complete information in response to certain screening questions is prohibited. ASF shall implement appropriate controls on dissemination of responses to questions asked related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by Employees or other Detainees. Sensitive information shall be limited to need-to-know Employees only for the purpose of treatment, programming, housing and security and management decisions." An interview with the Intake Supervisor confirmed detainees are not disciplined for refusing to answer the questions or for not disclosing complete information. The Auditor reviewed a memorandum to the file which states, "The Alexandria Staging Facility has not had a 60–90-day reassessment required in the audit period." Interviews with the facility PA and PSA Compliance Manager confirmed they have not had a detainee housed at the facility long enough to complete a 60-day reassessment. The Auditor reviewed the one sexual abuse allegation investigation file and confirmed the detainee victim had departed from the facility the following day; and therefore, a reassessment could not be conducted.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (g) of the standard. During the on-site audit, the Auditor partially observed the intake process and confirmed the housing unit assignment of each detainee was already known by observing detainees classified as high-level being lined up outside the high-level housing unit and then instructed to enter the unit and find themselves a cell with an empty bed. While on the housing unit the Auditor informally interviewed several detainees who confirmed they had to pick a bed which already had one detainee in the cell. The Auditor interviewed 23 detainees to include 5 detainees who had gone through the intake process the evening prior to the interview and confirmed the five detainees who were processed the evening prior to the interview had been asked the initial risk assessment questions on the initial risk assessment; however, two of the detainees indicated they had been woken up in the middle of the night to answer the questions and the remaining three detainees confirmed they had been asked the initial risk assessment questions just prior to the Auditor's visit to the unit the following morning. In addition, during the on-site Audit the Auditor observed the facility maintained the completed risk assessments in a locked cabinet located in the Intake Supervisor's office; however, interviews with the remaining 18 detainees confirmed although they were asked the initial risk assessment questions, they had lied in answering them as there were other detainees in the room, completing medical assessments and they did not want the other detainees to know their sexual preference or if they had experienced sexual abuse, so they indicated "no" when asked; and therefore, the Auditor could not confirm the facility has implemented appropriate controls on the dissemination of responses to the initial risk assessment to ensure sensitive information provided is not exploited to the detainees detriment by other detainees. To become compliant, the facility must assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and must house all detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger to include a practice to keep newly arrived detainees separate from the general population until the detainee is classified and may be housed accordingly. In addition, the facility must ensure initial classification and housing assignment is completed within 12 hours of admission into the facility. Once implemented the facility must submit documentation which confirms all Processing Officers have received training on the updated practices. In addition, the facility must implement a practice to ensure appropriate controls on the dissemination of responses to the initial risk assessment are in place, so sensitive information provided is not exploited to the detainee's detriment by other detainees. The facility must submit 20 detainee files which confirm compliance with subsections (a) and (b) of the standard that occur during the CAP period.

Corrective Action Taken:

The facility submitted a revised Post Order Intake/Processing Officer and a revised Post Order Intake Supervisor. The Auditor reviewed the revised post orders and confirmed the revised post orders included "The SAAPI Risk Assessment was revised to include the time of arrival and time of assessment completion to definitively show completion of the assessment within the required 12-hour timeframe and Intake processing officers are required to notate the time of arrival and time of assessment on the assessment form to be completed within the required 12-hour timeframe. A review of the revised post orders further confirmed "Processing officers will notify the shift supervisor immediately when victims/abusers are identified during the PREA risk assessment scoring process" and "the "at risk log" for tracking victims/abusers will be completed by the shift supervisor to ensure detainees are housed appropriately. In addition, a review of the revised post orders confirmed they include "Once per shift, the shift supervisor will make copies and scan all risk assessments that score as a victim/abuser to be forwarded to the ASF "PREA Referrals" digital mailbox" and "original PREA risk assessments are to be filed in the detainee's detention file." The facility submitted an email sent to all ASF staff, with read receipts, which included the same verbiage as the revised post orders. The facility submitted training sign-in documentation which confirms staff have received training on "The SAAPI Risk Assessment" being revised to include the time of arrival and time of assessment completion to definitively show completion of the assessment within the required 12-hour timeframe; Intake processing officers are required to notate the time of arrival and time of assessment on the assessment form to be completed within the required 12-hour timeframe; Processing officers will notify the shift supervisor immediately when victims/abusers are identified during the PREA risk assessment scoring process; the "at risk log" for tracking victims/abusers will be completed by the shift supervisor to ensure detainees are housed appropriately; once per shift, the shift supervisor will make copies and scan all risk assessments that score as a victim/abuser to be forwarded to the ASF "PREA Referrals" digital mailbox; and original PREA risk assessments are to be filed in the detainee's detention file. A review of the training curriculum further confirms applicable staff have received training to include "During the completion of the assessment tool, officers will advise each detainee they have the option to answer any or all of the questions non-verbally, by either clearly nodding (for a "yes" answer) or clearly shaking (for a "no" answer) their heads. This is to ensure sensitive information provided is not exploited to the detainee's detriment." The facility submitted 20 SAAPI Risk Assessments. The Auditor reviewed the submitted risk assessments and confirmed the initial risk assessment had been completed within 12 hours of arrival at the facility and the facility reviewed the assessment prior to making the housing decision for each detainee confirmed compliance with subsections (a) and (b) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (g) of the standard.

§115.42 - Use of assessment information.

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

Notes:

(a): ASF policy 10.1.1 states, "Screening information from standard Section C (1) shall be used to inform assignment of Detainees to housing, recreation, and other activities. ASF shall make individualized determinations about how to ensure the safety of each Detainee." During the on-site audit, the Auditor partially observed the intake process. The facility had received over 150 detainees, at one time, and it approximately 4:00 p.m. The detainees were brought into the facility and seated in the airport seating area. The Auditor observed and confirmed the housing unit assignment of the detainees were already known. Detainees classified as high-level were called and lined up outside the housing unit. The detainees were uncuffed and pat-searched, given bedding and shower shoes, and instructed to enter the unit and find themselves an empty bed within the cells. The high-level housing unit, have two-person cells. Informal interviews with several detainees, indicated that they had to pick a bed, that already had one detainee in the cell. Once all of the high-level detainees had chosen their bed, they were instructed to sit in the common area of the housing unit and watch the orientation video. The Auditor had left the facility for the day before the end of the video; however, the Auditor interviewed

two processing officers, and was walked through the remained of the process. Detainees are taken into the processing officer's office which is located inside the housing unit. The processing office is shared with medical staff and divided halfway with a partition. Detainees are asked the questions on the risk assessment while medical staff are conducting their initial assessment of other detainees. If a detainee discloses, he has experienced sexual abuse or has been sexually abusive, the processing officer will notify the Intake supervisor, who will come and sign the assessment. The following morning, the Auditor interviewed five detainees. Each detainee had been asked the questions on the assessments, two of the detainees reported that they had been woken up in the middle of the night to answer the questions. The other three detainees reported that they had been asked the questions, just prior to my arrival in the unit, which was after 9:00 a.m. Through-out the on-site audit, the Auditor interviewed a total of twenty-three detainees, which includes the five stated above. Several detainees reported that although they were asked the questions, they admitted to the Auditor that they had lied in answering them. When asked to explain, they indicated that the questions are personal in nature, there were other detainees in the room, completing a medical assessment, one detainee indicated that there were three other detainees in the room when he was asked the questions. Each detainee stated they could hear the other detainees answering the medical questions and did not want the detainee population to know their sexual preference or if they had been previously sexually abused, so they indicated "no" when asked. Two of the detainees shared with the Auditor, they were gay and had experienced sexual abuse in their lifetime. The Auditor reviewed 18 detainee files and confirmed an assessment had been completed. In an interview with the facility PA, it was confirmed detainees are only at the facility until their flights are arranged; and therefore, screening for recreation and other activities, and volunteer programing does not apply.

(b)(c): ASF policy 10.1.1 states, "When making assessments and housing decisions for Transgender and Intersex Detainees, ASF shall consider the Detainee's gender self-identification and an assessment of the effects of placement on the Detainee's health and safety. A Medical or Mental Health Practitioner shall be consulted as soon as practicable on these assessments and placement decisions which shall not be based solely on the identity documents or physical anatomy of the Detainee. The Detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. Housing and programming assignments for each Transgender and Intersex Detainee shall be reassessed at least twice each year to determine any threats to safety experienced by the Detainee. This assessment is completed by the PREA PSA Compliance Manager. Serious consideration shall be given to the individual's own views with respect to his/her own safety. When operationally feasible, Transgender and Intersex Detainees shall be given an opportunity to shower separately from other Detainees." Interviews with the PSA Compliance Manager, the Intake Supervisor and three random detention officers confirmed the facility does not house transgender detainees. Known transgender detainees are not brought to the facility and if a detainee indicates they are a transgender detainee, the detainee would be transferred to another ICE facility within close proximity.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. During the on-site audit, the Auditor partially observed the intake process. The facility had received over 150 detainees, at one time, and at approximately 4:00 p.m. The detainees were brought into the facility and seated in the airport seating area. The Auditor observed and confirmed the housing unit assignment of the detainees were already known. Detainees classified as high-level were called and lined up outside the housing unit. The detainees were uncuffed and pat-searched, given bedding and shower shoes, and instructed to enter the unit and find themselves an empty bed within the cells. The high-level housing unit, have two-person cells. Informal interviews with several detainees, indicated that they had to pick a bed, that already had one detainee in the cell. Once all of the high-level detainees had chosen their bed, they were instructed to sit in the common area of the housing unit and watch the orientation video. The Auditor had left the facility for the day before the end of the video; however, the Auditor interviewed two processing officers, and was walked through the remained of the process. Detainees are taken into the processing officer's office which is located inside the housing unit. The processing office is shared with

medical staff and divided halfway with a partition. Detainees are asked the questions on the risk assessment while medical staff are conducting their initial assessment of other detainees. If a detainee discloses, he has experienced sexual abuse or has been sexually abusive, the processing officer will notify the Intake supervisor, who will come and sign the assessment. The following morning, the Auditor interviewed five detainees. Each detainee had been asked the questions on the assessments, two of the detainees reported that they had been woken up in the middle of the night to answer the questions. The other three detainees reported that they had been asked the questions, just prior to my arrival in the unit, which was after 9:00 a.m. Through-out the on-site audit, the Auditor interviewed a total of twenty-three detainees, which includes the five stated above. Several detainees reported that although they were asked the questions, they admitted to the Auditor that they had lied in answering them. When asked to explain, they indicated that the questions are personal in nature, there were other detainees in the room, completing a medical assessment, one detainee indicated that there were three other detainees in the room when he was asked the questions. Each detainee stated they could hear the other detainees answering the medical questions and did not want the detainee population to know their sexual preference or if they had been previously sexually abused, so they indicated "no" when asked. Two of the detainees shared with the Auditor, they were gay and had experienced sexual abuse in their lifetime. The Auditor reviewed 18 detainee files and confirmed an assessment had been completed. To become compliant, during intake, the facility shall assess all detainees to identify those likely to be sexual aggressors or sexual abuse victims and shall use the information to inform housing. The facility shall provide at least 20 detainee files to include the date and time of admission to ASF, the date, and time the initial risk assessment is completed, and the date and time, of the detainees initial housing assignment.

Corrective Action Taken:

The facility submitted a revised Post Order Intake/Processing Officer and a revised Post Order Intake Supervisor. The Auditor reviewed the revised post orders and confirmed the revised post orders included "The SAAPI Risk Assessment was revised to include the time of arrival and time of assessment completion to definitively show completion of the assessment within the required 12-hour timeframe and Intake processing officers are required to notate the time or arrival and time of assessment on the assessment form to be completed within the required 12-hour timeframe. A review of the revised post orders further confirmed "Processing officers will notify the shift supervisor immediately when victims/abusers are identified during the PREA risk assessment scoring process" and "the "at risk log" for tracking victims/abusers will be completed by the shift supervisor to ensure detainees are housed appropriately. In addition, a review of the revised post orders confirmed they include "Once per shift, the shift supervisor will make copies and scan all risk assessments that score as a victim/abuser to be forwarded to the ASF "PREA Referrals" digital mailbox" and "original PREA risk assessments are to be filed in the detainee's detention file." The facility submitted an email sent to all ASF staff, with read receipts, which included the same verbiage as the revised post orders. The facility submitted training sign-in documentation which confirms staff have received training on "The SAAPI Risk Assessment" being revised to include the time of arrival and time of assessment completion to definitively show completion of the assessment within the required 12-hour timeframe; Intake processing officers are required to notate the time of arrival and time of assessment on the assessment form to be completed within the required 12-hour timeframe; Processing officers will notify the shift supervisor immediately when victims/abusers are identified during the PREA risk assessment scoring process; the "at risk log" for tracking victims/abusers will be completed by the shift supervisor to ensure detainees are housed appropriately; once per shift, the shift supervisor will make copies and scan all risk assessments that score as a victim/abuser to be forwarded to the ASF "PREA Referrals" digital mailbox; and original PREA risk assessments are to be filed in the detainee's detention file. A review of the training curriculum further confirms applicable staff have received training to include "During the completion of the assessment tool, officers will advise each detainee they have the option to answer any or all of the questions non-verbally, by either clearly nodding (for a "yes" answer) or clearly shaking (for a "no" answer) their heads. This is to ensure sensitive information provided is not exploited to the detainee's detriment." In addition, the facility submitted an email sent to all ASF staff which included the same verbiage as the post orders. The facility

submitted 20 SAAPI Risk Assessments confirming the initial risk assessment had been completed within 12 hours of arrival at the facility and the facility reviewed the assessment prior to making housing decisions for each detainee. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

§115.51 - Detainee reporting.

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

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "ASF shall provide multiple ways for Detainees to privately report Sexual Abuse and Assault, retaliation for reporting Sexual Abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. ASF shall provide contact information to Detainees for relevant consular officials and officials, the DHS Office of Inspector General or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents. ASF shall provide Detainees contact information on how to report Sexual Abuse or Assault to a public or private entity or office that is not part of GEO (i.e. contracting agency ICE) and that is able to receive and immediately forward Detainee reports of Sexual Abuse to Facility or GEO officials, allowing the Detainee to remain anonymous upon request. ASF shall provide Detainees contact information on how to report Sexual Abuse or Assault to the Facility PSA Compliance Manager. Employees shall accept reports made verbally, in writing, anonymously and from third parties and shall promptly document any verbal reports. Employees reporting Sexual Abuse shall be afforded the opportunity to report such information to the Chief of Security or upper-level executive privately if requested." The Auditor observed information in English and Spanish that advised detainee's how to contact their consular official, the DHS OIG, and DRIL, and the designated facility PREA Hotline to confidentially and if desired anonymously report an incident of sexual abuse posted in all common areas of the facility, including in close proximity to the detainee telephones. In interviews with PSA Compliance Manager and three detention officers indicated detainees are provided multiple ways to report sexual abuse, retaliation and any staff neglect of their responsibilities that may have contributed to an incident of sexual abuse. In addition, the three detention officers indicated that all reports received verbally, in writing, anonymously and from third parties must be promptly reported and documented. Detainees can report to the facility utilizing the PREA Hotline from the detainee phones. During the on-site audit, the Auditor tested all phone numbers provided to the detainees. Phone calls made to DHS OIG, DRIL and the JIC were completed and confirmed to be in good working order. Phone calls made to RAINN, the facility PREA Hotline and the consular officials, were not properly working. The facility immediately began to look into the issue and the facility provided email documentation to indicate the issue had been fix. Prior to the Auditor concluding the on-site audit, the Auditor confirmed the numbers were in good working order. However, the Auditor reviewed one investigative file which indicated on March 1, 2022, a detainee family member had contacted OIG in reference to a report of sexual abuse. The facility provided the Auditor with email documentation, that indicated the OIG office did not immediately report the allegation to the Agency or the facility. OIG reported the allegation on March 15, 2022. An investigation was immediately started; however, the victim detainee had been removed from the facility. In addition, during the investigation, it was determined that the victim detainee had notified a staff member of the allegation, prior to the report being made to OIG. The staff member failed to report the allegation.

Corrective Action:

The facility is not in compliance with subsections (a)(b) and (c) of the standard. The Auditor reviewed one investigative file which indicated on March 1, 2022, a detainee family member had contacted OIG in reference to a report of sexual abuse. The facility provided the Auditor with email documentation, that indicated the OIG office did not immediately report the allegation to the Agency or the facility. OIG reported the allegation on March 15, 2022. An investigation was immediately started; however, the victim detainee had been removed from the facility. In addition, during the investigation, it was determined that the victim detainee had notified a staff

member of the allegation, prior to the report being made to OIG. The staff member failed to report the allegation. To become compliant, the Agency shall review all documentation available regarding this allegation, to determine the reasoning behind the outside agency's failure to immediately report the allegation to the Agency or facility. The Agency shall implement any corrective action needed to ensure the outside agency is able to immediately forward all allegations received on behalf of a detainee in their care. Documentation of the review and any corrective action implemented, shall be forwarded to the Auditor. The facility shall re-train all staff on their responsibilities to immediately report any knowledge, suspicion, or information, they receive regarding an incident of sexual abuse and all reports received must be documented. Documentation of the training curriculum and staff participation in the training shall be provided to the Auditor. In addition, if applicable, the facility shall forward any investigations of detainee allegations of sexual abuse to the Auditor, that are completed during the corrective action phase of the audit.

Corrective Action Taken:

The facility submitted signed training documentation which indicates staff have received training on "All ASF staff are responsible and required to immediately report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties should he/she become aware of such an incident. All reports received must be documented."
The facility submitted a memorandum from the Agency PSAC which states, "ICE OPR recognizes this does not align with the definition of "immediate notification" as outlined in SAAPI standards and other established reporting policies. ICE OPR has met with DHS OIG and discussed delayed referrals/notifications and its impact on ICE's processes. The OPR Assistant Director, Investigations, had discussions pertaining to this matter with the OIG Assistant Inspector for Investigations, providing him with specific details relating to identified incidents where the delayed notification occurred. The DHS OIG indicated their commitment to addressing these notification deficiencies going forward. Additionally, OPR offered the assistance of the ICE Prevention of Sexual Assault Coordinator in developing a process to ensure compliance with PREA regulations. OPR will continue to collaborate with DHS OIG to establish a process that ensures immediate notification of all sexual assault and abuse allegations. This will ensure future incidents are reported in accordance with SAAPI standards and ICE policy. ICE remains committed to protecting the safety, health, and well-being of those in custody." The Auditor accepts the memorandum from the Agency PSAC as confirmation ICE OPR has taken steps to rectify the Agency deficiency. The facility submitted a memorandum to the file, which states, "There were no closed allegations of sexual abuse investigation files which occurred during the CAP Period." The Auditor now finds the facility in substantial compliance with subsections (a), (b), and (c) of the standard.

§115.61 - Staff reporting duties.

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

Notes:

(a)b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." ASF policy 10.1.1 states, "Employees are required to immediately report, in accordance with Agency policy, any of the following: 1) Knowledge, suspicion, or information regarding an incident of Sexual Abuse or Assault that occurred in a Facility

whether or not it is a GEO Facility; 2) Retaliation against Detainees or Employees who reported such an incident or participated in an investigation about such incident; and, 3) Any Employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, Employees shall not reveal any information related to a Sexual Abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other Detainees or staff in the Facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions. Employees reporting Sexual Abuse shall be afforded the opportunity to report such information to the Chief of Security or upper-level executive privately if requested and may also utilize the employee hotline or contact the Corporate PREA Coordinator directly to privately report these type incidents. Allegations of Sexual Abuse in which the alleged victim is under the age of 18 or considered a vulnerable adult under State or local vulnerable person's statute, ASF shall report to designated State or local services Agencies under applicable mandatory reporting laws." ASF policy 10.1.1 further states, "Contractors are required to immediately report any of the following: 1) Knowledge, suspicion, or information regarding an incident of Sexual Abuse or Assault that occurred in a Facility whether or not it is a GEO Facility; 2) Retaliation against Detainees or Employees who reported such an incident; and, 3) Any Employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, Contractors shall not reveal any information related to a Sexual Abuse report to anyone. Volunteers are required to immediately report any of the following: 1) Knowledge, suspicion, or information regarding an incident of Sexual Abuse or Assault that occurred in a Facility whether or not it is a GEO Facility; 2) Retaliation against Detainees or Employees who reported such an incident; and 3) Any Employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, Volunteers shall not reveal any information related to a Sexual Abuse report to anyone." Interviews with three random DOs confirmed they were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Interviews with three random DOs further indicated they were aware reports of sexual abuse must be kept in confidence and shared with only those who need-to-know. In addition, interviews with three random DOs confirmed they are aware of their ability to make a report outside the chain of command through the "employee hotline" which the Auditor confirmed was outside the chain of command. An interview with the facility PA confirmed the facility would not house a juvenile detainee and if the facility received an allegation of sexual abuse that involved a vulnerable adult a report would be made to the FOD and Adult Protective Services and/or the Elderly Protective Services. The Auditor reviewed one sexual abuse allegation investigation file and confirmed an allegation of sexual abuse had been made to a high-ranking staff member who failed to report the allegation.

Corrective Action:

The facility is not in compliance with subsection (b) of the standard. The Auditor reviewed one investigative file and confirmed an allegation of sexual abuse had been made to a high-ranking staff member who failed to report the allegation. To become compliant, the facility must document that all staff have received refresher training on the standard's requirement to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. In addition, if applicable, the facility must submit all sexual abuse allegation investigations that occur during the CAP period.

Corrective Action Taken:

The facility submitted training rosters which confirmed staff have received training on "All ASF staff are responsible and required to immediately report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties should he/she become aware of such an incident. All reports received must be documented." The facility submitted a memorandum to the file, which states, "There were no closed allegations of sexual abuse investigation files which occurred during the CAP

Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

§115.65 - Coordinated response.

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

Notes:

(a)(b)(c)(d): ASF policy 10.1.1 states, "ASF shall develop written Facility plans to coordinate the actions taken by staff first responders, Medical and Mental Health Practitioners, investigators, and Facility leadership in response to incidents of Sexual Abuse and Assault. ASF shall use a coordinated, multidisciplinary team approach to responding to Sexual Abuse and Assault. The PSA Compliance Manager shall be a required participant and the Corporate PREA Coordinator may be consulted as part of this coordinated response. If the victim of Sexual Abuse is transferred between DHS Immigration Detention Facilities, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services. If the victim of Sexual Abuse is transferred to a non-DHS Facility, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. Facilities shall utilize the "Notification of PREA Incident" form (See Attachment A of GEO Corporate Policy 5.1.2 - D)." The Auditor reviewed the facility PREA Coordinated Response Plan. A review of the plan confirmed the coordination of the actions taken by the first responders, medical and mental health practitioners, investigators, and the facility leadership in response to an incident of sexual abuse. However, a review of the PREA Coordinated Response Plan confirmed the plan does not include the requirements subsection (c) of the standard which states, "If a victim of sexual abuse is transferred between facilities covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or subsection (d) of the standard which states, "If a victim is transferred from a DHS immigration detention facility to a facility, not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise."

Corrective Action:

The facility is not in compliance with subsections (c) and (d) of the standard. The Auditor reviewed the facility PREA Coordinated Response Plan and confirmed the plan requires if the victim of Sexual Abuse is transferred between DHS Immigration Detention Facilities, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services and if the victim of Sexual Abuse is transferred to a non-DHS Facility, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. However, subsections (c) and (d) of the standard requires if a victim of sexual abuse is transferred between facilities covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and if a victim is transferred from a DHS immigration detention facility to a facility, not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. To become complaint, the facility must revise the PREA Coordinated Response plan to include subsections (c) and (d) of the standard. Once the PREA Coordinated Response plan has been revised, the facility must submit documentation to confirm all applicable staff, to include medical and mental health, have received training on the implemented PREA Coordinated Response plan. If applicable the facility must submit all detainee sexual abuse allegation investigation files that include detainees who have been transferred from ASF during the CAP period.

Corrective Action Taken:

The facility submitted an updated coordinated response plan which states "If a victim of sexual abuse is transferred between PREA DHS facilities the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and (d) if a victim is transferred from a PREA DHS immigration detention facility to a facility not a PREA DHS facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. The facility submitted signed training rosters which confirmed medical and mental health staff have received training on the requirements of subsections (c) and (d) of the standard to include if a victim of sexual abuse is transferred between PREA DHS facilities the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and (d) if a victim is transferred from a PREA DHS immigration detention facility to a facility not a PREA DHS facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. The facility submitted a memorandum to the file, which states, "There have been no detainee sexual abuse allegation investigation files that include detainees who have been transferred from ASF due to being a victim of sexual abuse that occurred during the CAP Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (c) and (d) of the standard.

§115.67 - Agency protection against retaliation.

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

Notes:

(a)(b)(c): ASF policy 10.1.1-A states, "ASF shall employ multiple protection measures, such as housing changes or transfers for victims or abusers, removal of alleged staff or Detainee abusers from contact with victims, and emotional support services for victims or staff who fear retaliation for reporting Sexual Abuse or Assault or for cooperating with investigations." ASF policy 10.1.1 states, "ASF's PSA Compliance Manager or Mental Health personnel shall be responsible for monitoring retaliation. A Mental Health staff member or the PSA Compliance Manager shall meet weekly with the alleged victim in private to ensure that sensitive information is not exploited by staff or others and to see if any issues exist. Any issues discussed shall be noted on the "Protection from Retaliation Log (see Attachment E)", to include corrective actions taken to address the issue. For at least 90 days following a report of Sexual Abuse, ASF shall monitor the conduct and treatment of Individuals in a GEO Program or Employees who reported the Sexual Abuse to see if there are changes that may suggest possible retaliation by Detainees or staff and shall act promptly to remedy such retaliation. Items to be monitored for Detainees include disciplinary reports and housing or program changes. Items to be monitored for Employees include negative performance reviews and Employee reassignments which shall be monitored by the Human Resources Department, or an Investigator as designated by the Facility Administrator utilizing the Employee Protection from Retaliation Log. If any other individual expresses a fear of retaliation, the Staff shall take appropriate measures to protect that individual as well. Completed Logs shall be retained in the investigative file of the corresponding PREA incident." An interview with the PSA Compliance Manager indicated she is responsible for retaliation monitoring of detainee victims of sexual abuse and witnesses who participate in an investigation. An interview with the PSA Compliance Manager further indicated she would begin detainee monitoring the week after the allegation is made and would continue until the allegation is determined to be unfounded or up to 90 days and longer if needed. In addition, an interview with the PSA Compliance Manager indicated she utilizes the GEO Protection from Retaliation Log to document retaliation monitoring. An interview with the PSA Compliance Manager confirmed she was very knowledgeable regarding monitoring disciplinary reports, housing changes, or program changes; however, she could not articulate the steps to be taken for monitoring a staff member if there was a need to do so or who was responsible for monitoring staff.

Corrective Action:

The Agency and facility are not in compliance with subsection (c) of the standard. An interview with the PSA Compliance Manager confirmed she would begin the monitoring of detainees the week after the allegation is made and would continue until the allegation is determined to be unfounded or up to 90 days and longer if needed. In an interview with the PSA Compliance Manager, it was further confirmed the PSA Compliance Manager could not articulate the steps taken for the monitoring of staff should there be a need to do so. In addition, in an interview with the PSA Compliance Manager it was confirmed there is no one responsible to monitor staff. To become compliant, the Agency and facility must implement a process to ensure all detainees who make an allegation of sexual abuse are monitored for at least 90 days regardless of it the allegation is determined to be unfounded. In addition, the Agency and facility must implement a process to ensure staff who report sexual abuse, and/or participates in the investigation, is monitored for retaliation to include reviewing negative performance reviews and staff reassignments. Once both processes have been implemented the facility must submit documentation to confirm all applicable staff, to include the PSA Compliance Manager, have received training on the standard's requirements. In addition, if applicable the facility must submit all sexual abuse allegation investigation files and the corresponding retaliation monitoring that occur during the CAP period.

Corrective Action Taken:

The facility submitted a memorandum from the HRM, the PSA Compliance Manager, and the ASF PREA Investigator which includes a statement confirming the reader understands the requirement which states, "This memorandum serves as an acknowledgment that GEO Contract Compliance Manager (CCM) has provided me with the training on the requirements of Sexual Abuse and Assault Prevention Standard 115.67 Agency protection against retaliation. The following standard requirements were addressed in their entirety. §115.67 Agency protection against retaliation a) Staff, contractors, and volunteers, and immigration detention facility detainees, shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. b) The agency shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. c) For at least 90 days following a report of sexual abuse, the agency and facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the agency should monitor include any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. DHS shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The facility submitted a memorandum to the file, which states, "There have been no sexual abuse allegation investigations and the corresponding monitoring documentation which occurred during the CAP Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (c) of the standard.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b): ASF policy 10.1.1-A states, "Criminal and Administrative Agency Investigations- a. An administrative or criminal investigation shall be completed for all allegations of Sexual Abuse. b. The Facility Administrator and contracting agencies shall be notified prior to investigating all allegations of Sexual Abuse. c. Specific procedures not listed in this policy which are required by contractual obligations shall be followed. Where any requirements of the DHS PREA Standards may conflict with PBNDS 2011, the DHS PREA Standards shall supersede. (i) Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; (ii) Interviewing alleged victims, suspected perpetrators, and witnesses; (iii)

Reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; (iv) Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph; (v) An effort to determine whether actions or failures to act at the facility contributed to the abuse; and (vi) Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and (vii) Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. When ASF conducts its own investigations into allegations of Sexual Abuse, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. ASF shall use investigators who have received specialized training in Sexual Abuse investigations. The specialized training shall include techniques for interviewing Sexual Abuse victims, proper use of Miranda and Garrity warnings, Sexual Abuse evidence collection and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. e. When outside agencies investigate Sexual Abuse, ASF shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Facilities shall request copies of completed investigative reports. Upon receipt, the investigative report will be forwarded to the Corporate PREA Director for review and closure." ASF policy further states, 10.1.1-A further states, "An investigative report shall be written for all investigations of allegations of Sexual Abuse. ASF shall utilize the investigative report template (See attachment A) for all PREA investigations unless another format is required by the contracting agency. b. Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of Sexual Abuse involving the suspected perpetrator. c. administrative investigations (1) shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) shall be documented in a written report format that includes at a minimum, a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings." An interview with the PSA Compliance Manager/Investigator, indicated the facility will complete an administrative investigation on all allegations as soon as RPSO and the ICE OPR indicates an investigation can begin. An interview with the PSA Compliance Manager/Investigator further indicated she would remain in constant contact with the RPSO, and a sexual abuse allegation investigation would continue regardless of if the victim or the abuser (staff or detainee) is no longer at the facility. The Auditor reviewed and confirmed the facility Investigator is qualified and has completed specialized training in sexual abuse and effective cross-agency coordination and the facility general PREA training as required by §115.31. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not contain include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the sexual abuse allegation investigation included the elements required by the standard.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (e) of the standard. The Auditor reviewed ASF policy 10.1.1-A and confirmed it includes all elements required by subsection (c) of the standard. However, the Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not contain include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the sexual abuse allegation investigation included the elements required by the standard. To become compliant the facility must submit documentation to confirm the facility Investigator has received training on the standard's requirement to ensure all allegations of sexual abuse are investigated in accordance with subsections (a), (b), (c), (e), and (f) of the standard. In addition, if applicable, the facility must submit all sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action Taken:

The facility submitted facility policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection. The Auditor reviewed facility policy 10.1.1-A and confirmed facility policy 10.1.1-A includes the requirements of subsections (a), (b), (c), (e), and (f) of the standard. In addition, the facility submitted an email addressed to the ASF PREA Investigator with sign-off to confirm the ASF PREA Investigator received training on facility policy 10.1.1-A. The facility submitted a memorandum to the file, which states, "There have been no sexual abuse allegation investigation files which occurred during the CAP Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), and (e) of the standard.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse." ASF policy 10.1.1-A states, "Facilities shall impose no standard higher than a preponderance of the evidence in determining whether allegations of Sexual Abuse are Substantiated." An interview with the PSA Compliance Manager/Investigator confirmed the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not contain include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the facility Investigator imposed no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse.

Corrective Action:

The facility is not in compliance with standard 115.72. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not contain include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the facility Investigator imposed no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse. To become compliant the facility must submit documentation to confirm the facility Investigator has received training on the standard's requirement to impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse. In addition, if applicable, the facility must submit all sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action Taken:

The facility submitted the facility policy 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection. The Auditor reviewed facility policy 10.1.1-A and confirmed facility policy 10.1.1-A includes the standard's requirement to impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse. In addition, the facility submitted an email addressed to the ASF PREA Investigator with sign-off to confirm the ASF PREA Investigator received training on facility policy 10.1.1-A. The facility submitted a memorandum to the file, which states, "There have been no sexual abuse allegation investigation files that occurred during the CAP Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with this standard.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f): ASF policy 10.1.1-A states, "ASF shall subject a Detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the Detainee engaged in Sexual Abuse. At all steps in the disciplinary process any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the Detainee to conform with rules and regulations in the future. ASF shall have a Detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure. The disciplinary process shall consider whether a Detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. ASF shall not discipline a Detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of Sexual Abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The PSA Compliance Manager shall receive copies of all disciplinary reports regarding Sexual Activity and Sexual Abuse for monitoring purposes." Interviews with the facility Disciplinary Officer, the PSA Compliance Manager, and the facility PA indicated although ASF policy 10.1.1-A and a review of the facility Supplement to the National Detainee Handbook confirms a hearing would be held and includes sanctions that can be imposed, the facility does not have the ability to discipline a detainee.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. Interviews with the facility Disciplinary Officer, the PSA Compliance Manager and the facility PA indicated although ASF policy 10.1.1-A and a review of the facility Supplement to the National Detainee Handbook confirms a hearing would be held and includes sanctions that can be imposed, the facility does not have the ability to discipline a detainee. To become compliant, the facility must establish a practice to ensure the facility subjects detainees to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse. Once implemented the facility must submit documentation which confirms all applicable staff, to include the Disciplinary Officer and PSA Compliance Manager, have been trained on the implemented practice. In addition, if applicable, the facility must submit any detainee-on-detainee sexual abuse allegation investigations determined to be substantiated and the corresponding disciplinary report that occur during the CAP period.

Corrective Action Taken:

The Auditor reviewed facility policy 10.3.10 and confirmed facility policy 10.3.10 states, "ASF has the ability to impose sanctions as identified in local policy 10.3.10 – Detainee Rules and Discipline." In addition, a review of facility policy 10.3.10 confirms facility policy 10.3.10 notifies staff when detainees charged with an infraction resulting from a SAAPI investigation are likely to be transferred or deported to their country of origin before commencement of disciplinary proceedings the Unit Disciplinary Committee has the ability to forward unresolved cases to the Institutional Disciplinary Panel. The facility submitted signed training rosters which confirmed all applicable staff, to include the Disciplinary Officer and PSA Compliance Manager, have received training on facility policy 10.3.10. The facility submitted a memorandum to the file, which states, "There have been no detainee-on-detainee sexual abuse allegations investigations determined to be substantiated and the corresponding disciplinary reports which occurred during the CAP Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

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

Outcome: Does not Meet Standard

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "If during the intake assessment, persons tasked with screening determine that a Detainee is at risk for either sexual victimization or abusiveness, or if the Detainee has experienced prior victimization or perpetrated sexual abuse, the Detainee shall be referred to a Qualified Medical and/or Mental Health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the Detainee shall receive a health evaluation no later than two (2) 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. Information related to sexual victimization or abusiveness in an institutional setting is limited only to Medical and Mental Health Practitioners and other Employees as necessary to inform treatment plans, security and management decisions or otherwise required by Federal, State, or local law." The Auditor interviewed two Processing Officers who indicated detainees are asked the questions on the initial risk assessment and if a detainee discloses, he has experienced sexual abuse or has perpetrated sexual abuse, they will notify the Intake supervisor who will come to the desk and sign the assessment. However, interviews with two Processing Officers confirmed the two Processing Officers could not articulate the requirement to refer detainees who disclose prior sexual abuse or have perpetrated sexual abuse to medical or mental health for a medical or mental health follow-up. The Auditor reviewed 18 detainee files and confirmed 1 detainee had reported previous sexual abuse and had previously been convicted of sexual assault of a child and the Intake Supervisor had initialed the initial risk assessment form; however, neither the Processing Officer or the Intake supervisor who initialed the initial risk assessment form referred the detainee to medical or mental health for a follow-up. Interviews with two RNs indicated if a detainee disclosed sexual abuse or perpetrated sexual abuse a referral would be forwarded to mental health staff for an evaluation; however, a referral would only be made if the sexual abuse occurred within the six months prior to Intake processing. Interviews with two RNs further indicated if a referral was received from Intake Processing a follow-up medical assessment would be conducted immediately but no later than two days following the referral. An interview with an LCSW indicated if a referral were received a follow-up medical assessment would be conducted immediately but no later than 72 hours following the referral.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The Auditor interviewed two Processing Officers who indicated detainees are asked the questions on the initial risk assessment and if a detainee discloses, he has experienced sexual abuse or has perpetrated sexual abuse, they will notify the Intake supervisor who will come to the desk and sign the assessment. However, interviews with two Processing Officers confirmed the two Processing Officers could not articulate the requirement to refer detainees who disclose prior sexual abuse or have perpetrated sexual abuse to medical or mental health for a medical or mental health follow-up. Interviews with two RNs indicated if a detainee disclosed sexual abuse or perpetrated sexual abuse a referral would be forwarded to mental health staff for an evaluation; however, a referral would only be made if the sexual abuse occurred within the six months prior to Intake processing. The Auditor reviewed 18 detainee files and confirmed 1 detainee had reported previous sexual abuse and had previously been convicted of sexual assault of a child and the Intake Supervisor had initialed the initial risk assessment form; however, neither the Processing Officer or the Intake supervisor who initialed the initial risk assessment form referred the detainee to medical or mental health for a follow-up. To become compliant, the facility must implement a process to ensure if the initial risk assessment indicates a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff will, as appropriate, ensure the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. Once implemented, the facility must submit documentation that confirms all applicable staff have been trained on the implemented process. In addition, the facility must provide the Auditor, if applicable, detainee files which include detainees who have previously experienced sexual abuse or who have perpetrated sexual abuse that are received during the CAP period to

confirm detainees who disclose prior sexual abuse or have perpetrated sexual abuse are referred to medical or mental health for a medical or mental health follow-up.

Corrective Action Taken:

The facility submitted signed training rosters which confirmed staff have received training to include intake staff and intake supervisory staff at ASF will scan and submit all assessments necessitating medical and/or mental health referrals to the ranking security supervisor on duty. The ranking security supervisor will update the facility "at risk log" and forward the referrals to IHSC staff as well as the PSACM within 24 hours of risk assessment completion. The PSACM will be responsible for monitoring completion of medical and/or mental health referrals and accuracy of the "at risk log". The facility submitted 15 detainee Medical/Mental Health Referral forms and the corresponding medical and mental health records. The Auditor reviewed the documentation submitted and confirmed although 15 referrals were made to mental health by intake staff only 10 mental health records confirmed mental health was aware of the detainee's need for a follow-up evaluation and only 3 detainees were seen by mental health staff as the other notes reflected the detainee refused services at intake. A review of the medical records submitted for each detainee further confirmed although the detainee was seen by medical for mental health concerns the reason for the appt was strictly for intake screening. In addition, a review of the medical records confirmed the mental health portion was completed by a Nurse Practitioner and subsection (a) of the standard requires an evaluation be conducted by a "qualified mental health practitioner." The facility submitted an excel spreadsheet which confirms none of the detainees referred by intake staff as a PREA risk were found to be a PREA risk during their medical intake screening. In addition, the Auditor reviewed the medical screening form and confirmed the screening form continues to require a referral to mental health only if the history of sexual abuse occurred within the last six months; and therefore, the Auditor could not confirm all detainees who report a history of sexual abuse, to include detainees whose abuse occurred prior to the preceding six months of intake, would be referred to mental health should they identify as experiencing prior sexual abuse during medical intake. Upon review of the submitted documentation the Auditor continues to find the facility does not meet subsection (a) of the standard.

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.

Robin Bruck 7/22/2024

Auditor's Signature & Date

(b) (6), (b) (7)(C) 7/23/2024

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 7/22/2024

Assistant Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	10/31/2023	**To:**	11/02/2023
AUDITOR INFORMATION			
Name of auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-(b) (6), (b) (7)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-(b) (6), (b) (7)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	New Orleans		
Field Office Director:	Mellissa Harper		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1250 Poydras Street, Suite 325 New Orleans, LA 70113		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Alexandria Staging Facility		
Physical address:	96 George Thompson Drive Alexandria, Louisiana 71303		
Telephone number:	318-483-1600		
Facility type:	Staging Facility		
PREA Incorporation Date:	6/19/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	318-910-(b) (6), (b) (7)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	318-922-(b) (6), (b) (7)

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.

Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of Alexandria Staging Facility (ASF) was conducted October 31-November 2, 2023, by U.S. Department of Justice (DOJ) and DHS Certified PREA Auditor Robin M. Bruck, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C) both DOJ and DHS Certified PREA Auditors. The PM's role is to provide oversight for the ICE PREA audit process and liaison with ICE Office of Professional Responsibilities (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility compliance with the DHS PREA Standards. ASF is privately operated by the GEO Group and operates under contract with the DHS, Immigration and Customs Enforcement (ICE), Office of Enforcement and Removal Operations (ERO). The facility Pre-Audit Questionnaire (PAQ) indicated the facility does not house juveniles or family detainees. ASF is in Alexandria, Louisiana. This audit is the facility's first DHS PREA audit under subpart A; however, the facility had previously undergone a DHS PREA audit under subpart B in 2018. The review includes the period from November 2, 2020, through November 2, 2023. As there were zero allegations of sexual abuse reported at ASF for the prior 12-months period, the audit period was extended to capture closed investigations which occurred since the facility's last audit.

Approximately 30 days prior to the on-site audit, the ERAU Inspections and Compliance Specialist (ICS) Team Lead (TL) (b) (6), (b) (7)(C) provided the Auditor with the facility Pre-Audit Questionnaire (PAQ), Agency policies, facilities policies, and other supporting documentation through the ICE SharePoint. The PAQ, policies, and supporting documentation had been organized utilizing the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into folders for ease of auditing. Prior to the on-site audit, the Auditor reviewed all documentation provided, the Agency website and the facility website. The main policy that governs ASF's sexual abuse prevention, intervention and response efforts is GEO 10.1.1 Sexual Assault and Abuse Prevention and Intervention.

An entrance briefing was held in the ASF's conference room on Tuesday, October 31, 2023, at 8:15 a.m. The ICE ERAU TL, (b) (6), (b) (7)(C) opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C) ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C) PSA Compliance Manager, GEO Group
(b) (6), (b) (7)(C) Corporate Compliance, GEO Group
(b) (6), (b) (7)(C) ASF Facility Administrator (FA), GEO Group
(b) (6), (b) (7)(C) ASF Compliance Administrator, GEO Group
(b) (6), (b) (7)(C) ASF Compliance Auditor, GEO Group
(b) (6), (b) (7)(C) ASF Major, GEO Group
(b) (6), (b) (7)(C) ASF Project Administrator (PA), GEO Group
(b) (6), (b) (7)(C) Facility Health Manager, ICE Health Service Corps (IHSC)
(b) (6), (b) (7)(C) Deputy Field Officer Director (DFOD), ICE/ERO
Robin M. Bruck, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC

The Auditor introduced herself and provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the general knowledge of staff at all levels employed at the facility. The Auditor

further explained compliance with the PREA standards will be determined based on a review of ASF policies and procedures, observations made during the facility on-site audit, documentation review, and interviews conducted with staff and detainees.

An on-site audit was conducted by the Auditor, with key staff from ASF GEO Group and ICE ERO. All areas of the facility were observed by the Auditor, which included all detainee housing units, and medical areas. In addition, the Auditor observed the sally port (both bus and airplane) and the control center. During the on-site audit, the Auditor made visual observations of the housing unit bathrooms and shower areas, officer post sight lines and camera locations. Sight lines were closely examined, as was the potential for blind spots, throughout the facility where detainees are housed or have access and there were no notable blind spots observed. The Auditors observed PREA information in all housing units and near the detainee telephones which included the DHS-prescribed sexual assault notice, the Detention and Reporting Information Line (DRIL) poster, contact information for DHS Office of Inspector General (OIG), Rape, Abuse & Incest National Network (RAINN), and contact information for the consular officials. The information was predominately in English and Spanish, which is the predominate languages of the detainee population housed at the facility at the time of the on-site audit. In addition, the Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor tested all telephone numbers provided to the detainees and confirmed all were in good working order.

ASF utilizes (b) (7)(E) to assist with monitoring the detainees. (b) (7)(E) were present in all areas of the facility. According to the PAQ (b) (7)(E) (b) (7)(E) however, in an interview with the PSA Compliance Manager, and Auditor observations, it was confirmed they (b) (7)(E) (b) (7)(E) (b) (7)(E). The Auditor reviewed (b) (7)(E) in the state of undress could be viewed.

A review of the ASF PAQ indicates the facility has 71 security staff, (21 male officers and 50 female officers), 9 food service staff, 3 administrative staff, and 1 maintenance worker who may have continuing contact with detainees. Additional staff include 18 ICE/ERO staff, 61 IHSC medical staff, and 2 mental health staff. In addition, the facility utilizes the services of one volunteer for religious services. Security staff work in two shifts 0600-1800, and 1800-0600. The facility provided the Auditor with staff rosters for staff interviews and file reviews. The Auditor conducted a total of 15 staff interviews which included 3 random Detention Officers (DOs) (1 male and 2 female), 2 security supervisors, Project Administrator (PA), Human Resource Manager (HRM), two ASF Processing Officers, Licensed Clinical Social Worker (LCSW), Grievance Officer (GO), Disciplinary Officer, Intake Supervisor, PSA Compliance Manager, and an Investigator. In addition, the Auditor interviewed two ICE staff to include the DFOD and a Supervisory Detention and Deportation Officer (SDDO), and two Registered Nurses (RNs) employed by IHSC. The Auditor did not conduct interviews of "other" contactors or volunteers as they were not in the facility during the on-site audit. All interviews were conducted in a private setting, allowing for confidentiality for those participating in the interview process.

The Auditor conducted 23 detainee interviews. All detainees interviewed were limited English proficient (LEP) and the Auditor conducted the interviews with the use of a language line through Language Line Service Associates (LSA) provided by Creative Corrections, LLC. In addition, all interviews were conducted in a private setting allowing for confidentiality for those participating in the interview process.

According to the PAQ the facility has one trained investigator who has been specially trained to conduct sexual abuse allegation investigations. In addition, a review of the facility PREA Allegation Spreadsheet indicated one sexual abuse allegation investigation file had been closed during the reporting period, detainee-on-detainee allegation, and was determined to be unsubstantiated.

An exit briefing was conducted on Thursday, November 2, 2023, at 2:00 p.m. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C) ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C) ASF PSA Compliance Manager, GEO Group
(b) (6), (b) (7)(C) ASF FA, GEO Group
(b) (6), (b) (7)(C) ASF Compliance Administrator, GEO Group
(b) (6), (b) (7)(C) ASF Compliance Auditor, GEO Group
(b) (6), (b) (7)(C) ASF Major, GEO Group
(b) (6), (b) (7)(C) ASF PA, GEO Group
(b) (6), (b) (7)(C) DFOD, ICE/ERO
(b) (6), (b) (7)(C) Corporate Compliance, GEO Group (via teleconference)
(b) (6), (b) (7)(C) Corporate PREA Director, GEO Group (via teleconference)
Robin M. Bruck, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC

The Auditor spoke briefly and informed those present it was too early in the process to formalize a determination of compliance on each standard. The Auditor further advised she would review all documentation, interview notes, file review notes, and on-site observations to determine compliance. The Auditor thanked all facility staff for their cooperation in this audit process. The TL explained the audit report process, timeframes for any corrective action imposed, and the timelines for the final report.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2

- §115.31 - Staff Training
- §115.32 - Other Training

Number of Standards Met: 24

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
- §115.13 - Detainee supervision and monitoring
- §115.15 - Limits to cross-gender viewing and searches
- §115.21 - Evidence protocols and forensic medical examinations
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight
- §115.32 - Other Training
- §115.34 - Specialized training: Investigations
- §115.35 - Specialized training: Medical and mental health care
- §115.43 - Protective Custody
- §115.52 - Grievances
- §115.53 - Detainee access to outside confidential support services
- §115.54 - Third-party reporting
- §115.62 - Protection Duties
- §115.63 - Reporting to other Confinement Facilities
- §115.64 - Responder Duties
- §115.66 - Protection of detainees from contact with alleged abusers
- §115.68 - Post-allegation protective custody
- §115.73 - Reporting to detainees
- §115.76 - Disciplinary sanctions for staff
- §115.77 - Corrective action for contractors and volunteers
- §115.82 - Access to emergency medical and mental health services
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review
- §115.87 - Data collection
- §115.201 - Scope of Audit

Number of Standards Not Met: 13

- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
- §115.17 - Hiring and promotion decisions
- §115.33 - Detainee education
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.51 - Detainee reporting
- §115.61 - Staff Reporting Duties
- §115.65 - Coordinated response
- §115.67 - Agency protection against retaliation

- §115.71 - Criminal and administrative investigations
- §115.72 - Evidentiary standard for administrative investigations
- §115.78 - Disciplinary sanctions for detainees
- §115.81 - Medical and mental health screening; history of sexual abuse

Number of Standards Not Applicable: 2

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

PROVISIONS

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

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

Outcome: Meets Standard

Notes:

(c): ASF policy 10.1.1 states, "Zero Tolerance (§115.11) ASF maintains a zero-tolerance policy for all forms of sexual abuse or assault. Where any requirements of the DHS PREA Standards may conflict with PBNDS 2011, the DHS PREA Standards shall supersede. The DHS Prevention of Sexual Assault Coordinator (PSA Coordinator) shall review and approve ASF's written policy and any subsequent changes." The policy includes definitions of sexual abuse and general PREA definitions. In addition, the policy outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment through, but not limited to, hiring practices, training, unannounced rounds, mandatory reporting, investigations, and support from victim advocates. During the on-site audit, the Auditor observed the DHS-prescribed sexual abuse and assault awareness notice posted in all housing units. Informal interviews with staff and formal interviews with three random DOs indicated they were knowledgeable regarding the facility's zero-tolerance policy. An interview with the DFOD and the facility PA indicated ASF policy 10.1.1 has been reviewed and approved by the Agency.

(d): ASF policy 10.1.1 states, "ASF has designated a local PSA Compliance Manager who shall serve as the Facility point of contact for the DHS PSA Coordinator and Corporate PREA Coordinator. PSA Compliance Manager duties include a. Gathering of Facility statistics and reports on incidents of Sexual Activity and Sexual Abuse; b. Assist with development/revision of any site specific PREA policies; c. Assist with PREA training initiatives; d. Assist with PREA Facility assessments; e. Prepare an annual report on findings and corrective actions for the Facility; f. Monitoring for retaliation in accordance to Section M2 of this policy." An interview with the PSA Compliance Manager, indicated she has sufficient time and authority to oversee the facility's efforts to comply with the facility sexual abuse prevention and intervention policies and procedures. In addition, the PSA Compliance Manager confirmed she serves as the facility point of contact for the Agency PSA Coordinator.

Corrective Action:

No corrective action needed.

§115.13 - Detainee supervision and monitoring

Outcome: Meets Standard

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "ASF shall ensure that it maintains sufficient supervision of Detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect Detainees against Sexual Abuse and Assault. ASF shall develop and document comprehensive Detainee supervision guidelines to determine and meet the Facility's Detainee supervision needs and shall review those guidelines at least annually. In determining adequate levels of Detainee supervision and determining the need for video monitoring, ASF shall take into consideration: 1) Generally accepted detention and correctional practices; 2) Any judicial findings of inadequacy; 3) The physical layout of each Facility; 4) The composition of the Detainee population; 5) The prevalence of substantiated and unsubstantiated incidents of Sexual Abuse; 6) The findings and recommendations of Sexual Abuse incident review reports; 7) Any other relevant factors, including but not

limited to the length of time Detainees spend in Facility custody. The "PREA Annual Facility Assessment" (see Attachment B Corporate Policy 5.1.2 - D), shall be completed and submitted to the local PSA Compliance Manager and Corporate PREA Coordinator annually as determined by GEO's U.S. Secure Services division. GEO's U.S. Corrections and Detention Division, in consultation with the Corporate PREA Coordinator, shall review all ASF Facility assessments and take appropriate actions necessary to protect Detainees from Sexual Abuse at ASF. All findings and corrective actions taken shall be documented by the Corporate PREA Coordinator." A review of the ASF PAQ indicates the facility has 71 security staff, (21 male officers and 50 female officers), 9 food service staff, 3 administrative staff, and 1 maintenance worker who may have continuing contact with detainees. Additional staff include 18 ICE/ERO staff, 61 IHSC medical staff, and 2 mental health staff. In addition, the facility utilizes the services of one volunteer for religious services. Security staff work two shifts 0600-1800, and 1800-0600. Interviews with the facility PA and PSA Compliance Manager indicated the facility considers all required elements of subsection (c) of the standard when determining adequate staffing levels and the need for video monitoring. The Auditor reviewed ASF's Annual PREA Facility Assessment, which is dated September 19, 2023 and confirmed the facility considered all elements required by subsection (c) of the standard to determine adequate staffing levels and the need for video monitoring to include; generally accepted detention and correctional practices, judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in the agency custody. During the on-site audit, the Auditor reviewed the facility comprehensive detainee guidelines and confirmed they had last been updated on February 6, 2023, and had been signed by all staff assigned to the respective posts. In addition, during the on-site audit the Auditor observed adequate staff within the facility. In an interview with the facility PA it was indicated (b) (7)(E) at the facility; however, the facility PA, the PSA Compliance Manager, and the Investigator have access to (b) (7)(E).

(d): ASF policy 10.1.1 states, "Supervisory staff (intermediate and high-level supervisors) shall conduct and document random unannounced security inspections to identify and deter staff sexual abuse and sexual harassment. These "PREA Unannounced Security Inspections" may be conducted in conjunction with other daily and weekly rounds as required. PREA Unannounced Security Inspections shall be conducted at least once per shift by the Assistant Shift Supervisor and Shift Supervisor. Daily Unannounced Security Inspections through each housing unit will be conducted by the Chief of Security and the Shift Supervisor documented in the housing unit logbook as PREA Unannounced Security Inspections in red ink. Other members of the executive team shall make less unannounced visits as schedules allow. Such inspections shall be implemented for night as well as day shifts. Employees are prohibited from alerting others that these security inspections are occurring, unless such announcement is related to the legitimate operational functions of ASF." Interviews with two security supervisors who conduct unannounced security inspections indicated they were very knowledgeable and could articulate the unannounced security inspections are conducted to identify and deter sexual abuse of detainees. Interviews with two staff members further indicated rounds are completed every day, on every shift, and at different times, so a pattern is not developed. During the on-site audit, the Auditor observed facility logbooks and confirmed unannounced security inspections are being conducted frequently, on every shift, at different times, and are documented.

Corrective Action:

No corrective action needed.

§115.14 - Juvenile and family detainees

Outcome: Not Applicable

Notes:

(a)(b)(c)(d): The Auditor reviewed a memorandum to the file which states, "The Alexandria Staging Facility does not hold juveniles or families." Interviews with the facility PA, PSA Compliance Manager, and Auditor on-

site observations confirmed the facility does not house juveniles or family units: and therefore, standard 115.14 is not applicable.

Corrective Action:

No corrective action needed.

§115.15 - Limits to cross-gender viewing and searches

Outcome: Meets Standard

Notes:

(b)(c)(d): ASF policy 10.1.1 states, "Searches may be necessary to ensure the safety of officers, civilians, and Detainees; to detect and secure evidence of criminal activity; and to promote security, safety, and related interest at Immigration Facilities. Searches shall be performed in the following manner: 1. Cross-gender pat-down searches of male Detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in Exigent Circumstances. 2. Cross-gender pat-down searches of female Detainees, absent Exigent Circumstances are prohibited." Interviews with three detention officers, indicated that cross-gender pat-down searches are prohibited at the facility without exigent circumstances. If exigent circumstances were to be present, the cross-gender pat-down search is documented on the Cross Gender Pat Search log. The Auditor reviewed the Cross Gender Pat Search log and confirmed there have not been cross-gender pat-down searches conducted at the facility. A review of the log further indicated the facility does not document the reason the cross-gender pat-down search was needed. During the on-site audit, the Auditor observed pat-down searches of detainees and confirmed the search was performed by staff of the same gender. The Auditor interviewed 23 detainees and confirmed all detainees had been subjected to a pat-down search at the facility and all pat-down searches were performed by a male officer.

Recommendation: The Auditor recommends the facility revise the Cross Gender Pat Search log to include the reasons a cross gender pat-down search had been conducted.

(e)(f): ASF policy 10.1.1 states, "All strip searches, visual body cavity searches and cross-gender pat-down searches shall be documented. (See Attachment C – Cross Gender Pat Search Log). Cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in Exigent Circumstances, including consideration of officer safety, or when performed by Medical Practitioners." Interviews with three random DOs indicated strip searches, cross-gender strip searches, visual body cavity searches, and cross-gender visual body cavity searches are prohibited; however, if exigent circumstances required a strip search, cross-gender strip search, visual body cavity search, or a cross-gender visual body cavity search to be conducted the search would be documented on the Strip Search log. Interviews with 23 detainees confirmed they had not been subjected to a strip search or a visual body cavity search while housed at the facility.

(g): ASF policy 10.1.1 states, "ASF shall implement policies and procedures which allow Detainees to shower, change clothes, and perform bodily functions without Employees of the opposite gender viewing them, absent Exigent Circumstances or instances when the viewing is incidental to routine cell checks or otherwise appropriate in connection with a medical examination or monitored bowel movement. Employees of the opposite gender shall announce their presence when entering housing units or any areas where Detainees are likely to be showering, performing bodily functions, or changing clothes. PREA announcements are to be documented in the housing unit log. Detainees who are placed on constant observation status by Mental Health Providers shall be provided visual supervision by a Security Staff member of the same gender." Interviews with three random DOs indicated opposite gender staff are required to announce their presence when entering a housing unit. During the on-site audit, the Auditor observed signage on the doors to remind staff of opposite gender announcement requirements when entering a housing unit. In addition, during the on-site audit the Auditor observed the announcement being made by the female staff. Interviews with 23 detainees confirmed female staff announce their presence when entering the housing unit. In addition, interviews with 23 detainees confirmed all detainees

felt they are afforded privacy when showering, performing bodily functions, and changing their clothing.
(h): ASF is not designated as a Family Residential Center; therefore, provision (h) is not applicable.

(i)(j): ASF policy 10.1.1 states, "Staff shall not search or physically examine a Detainee for the sole purposes of determining the Detainee's genital characteristics. If the Detainee's gender is unknown, it may be determined during conversations with the Detainee, by reviewing medical records, or by 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. Security Staff shall be trained to conduct pat-down searches, including cross-gender pat-down searches and searches of Transgender and Intersex Detainees in a professional and respectful manner, and in the least intrusive manner possible, including consideration of officer safety." The Auditor reviewed the facility Sexual Abuse and Assault Prevention and Intervention (PREA) training curriculum, which states, "Remember, the PREA Standards impose a complete ban on searching or physically examining a transgender or intersex detainee or resident for the sole purpose of determining their genital status." In addition, the training includes, "For example, respectful communication, consistency in technique, professionalism, and awareness of safety and security are the key elements I want everyone to focus on today." The Auditor reviewed a 2023 course enrollment report for the annual web-based "Detainee Searches" training and confirmed all ASF staff have completed the required training. Interviews with three random DOs confirmed their knowledge in performing pat-down searches. In addition, interviews with three random DOs confirmed each officer could articulate they could not search or physically examine a transgender or intersex detainee for the sole purpose of determining their genital status.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b): ASF policy 10.1.1 states, "ASF shall ensure that Detainees with disabilities (i.e., those who are deaf, hard of hearing, blind, have low vision, intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from the Company's efforts to prevent, detect, and respond to Sexual Abuse and Assault. ASF shall provide written materials to every Detainee in formats or through methods that ensure effective communication with Detainees with disabilities, including those who have intellectual disabilities, limited reading skills or who are blind or have low vision. Methods to ensure effective communication shall include, when necessary, access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation." During the on-site audit, the Auditor observed the facility PREA video available in English, Spanish and closed captioning, for the deaf or hard or hearing detainees. During the on-site audit the Auditor further observed the facility had the capabilities to print a transcription of the video, and translate it into other languages, if needed. Interviews with two Processing Officers, indicated during Intake processing, the detainees watch the video, are provided the facility local supplement handbook and if a detainee spoke a language other than English or Spanish, the "forms", (which include the Orientation Sign-In Sheet and the PREA Risk Assessment, which do not contain PREA information, such as zero-tolerance or how to report an allegation of sexual abuse), would be read to them with the use of the facility language line. The Auditor reviewed the facility's September 2023 Language line bill and confirmed, the language line had been utilized 445 times, during intake; however, the two Processing Officers could not articulate how PREA education, other than information available in the PREA video, would be provided to detainees who are LEP, deaf or hard of hearing , blind or have low vision, or who have intellectual, psychiatric, or speech disabilities. During the on-site audit, the Auditor observed an English and Spanish version of the ICE National Detainee Handbook posted in each housing unit; however, the Auditor did not observe a supply of the ICE National Detainee Handbook in Intake process, available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. In an interview with two Processing Officers, it was confirmed the two Processing Officers

could not articulate how detainees would receive the PREA information included in the ICE National Detainee Handbook if their preferred language was other than English or Spanish. In addition, during the on-site audit, the Auditor did not observe copies of the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet available in 15 most prevalent languages encountered by ICE, Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian; however, PREA information, to include the DHS-prescribed sexual assault awareness notice, the instructions and contact information for OIG, DRIL, and RAINN, available in English and Spanish only, was observed posted in all housing units. Interviews with 23 detainees, could not confirm, the detainees were provided access to PREA related information through in-person, telephonic, or video interpretive services that enabled effective, accurate and impartial interpretation. In addition, based on observation during the on-site audit, the Auditor could not confirm all written material related to sexual abuse was available in a format or through methods all detainees could understand to include detainees, who might be LEP, deaf or hard of hearing, blind or have low vision, or who have intellectual, psychiatric, or speech disabilities.

(c): ASF policy 10.1.1 states, "In matters relating to Sexual Abuse, ASF shall provide in-person or telephonic interpretation services that enable effective, accurate and impartial interpretation, by someone other than another Detainee, unless the Detainee expresses a preference for a Detainee interpreter and the Facility determines that such interpretation is appropriate. Minors, alleged abusers, Detainees who witnessed the alleged abuse, and Detainees who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of Sexual Abuse." The Auditor reviewed the Sexual Abuse and Assault Prevention and Intervention (PREA) 2017 In-Service training curriculum and confirmed the staff training mirrors the facility policy. Interviews with three random DOs, confirmed they would not utilize a detainee for interpretation unless requested by the detainee and approved by the supervisor. An interview with the facility PSA Compliance Manager/Investigator confirmed if the detainee requested another detainee to provide interpretation during an investigation into an allegation of sexual abuse the request and who provided the interpretation would be documented in the investigative report.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit the Auditor reviewed the facility's September 2023 Language line bill and confirmed, the language line had been utilized 445 times to translate the Intake Orientation Sign-In Sheet and the PREA Risk Assessment; however, the two Processing Officers could not articulate how PREA education would be provided to detainees who are LEP, deaf or hard of hearing, with the exception of the information provided in the PREA video, blind or have low vision, or who have intellectual, psychiatric, or speech disabilities. In addition, during the on-site audit, the Auditor observed an English and Spanish version of the ICE National Detainee Handbook posted in each housing unit; however, the Auditor did not observe a supply of the ICE National Detainee Handbook in Intake process, available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. In an interview with two Processing Officers, it was confirmed the two Processing Officers could not articulate how detainees would receive the PREA information included in the ICE National Detainee Handbook if their preferred language was other than English or Spanish. During the on-site audit, the Auditor did not observe in Intake processing copies of the DHS-prescribed SAA Information pamphlet available in 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian. Interviews with 23 detainees, could not confirm, the detainees were provided access to PREA education through in-person, telephonic, or video interpretive services to enable effective, accurate, and impartial interpretation. In addition, the Auditor could not confirm all written material related to sexual abuse was available in a format or through methods all detainees could understand to include detainees, who might be LEP, deaf or hard of hearing, blind or have low vision, or who have intellectual, psychiatric, or speech disabilities. To become compliant, the facility must implement a practice that ensures all detainees have an equal opportunity to participate or benefit from all aspects of both the Agency and facility efforts to prevent, detect, and respond to sexual abuse to include the

information available in the ICE National Detainee Handbook, the facility Supplemental to the National Detainee Handbook, DHS-prescribed SAA information pamphlet and any other PREA related information the facility makes available to detainees. Once implemented, the facility must submit documentation that confirms all Processing Officers have received training on the implemented practice. In addition, the facility must submit 15 detainee files, to include if applicable, detainees whose preferred language is other than English or Spanish, who are deaf or hard of hearing, who are blind or have low vision, who have intellectual, psychiatric, or speech disabilities, or have limited reading skills that occur during the Corrective Action Plan (CAP) period to confirm all detainees have an equal opportunity to participate or benefit from all aspects of both the Agency and facility efforts to prevent, detect, and respond to sexual abuse to include the information available in the ICE National Detainee Handbook, the facility Supplemental to the National Detainee Handbook, DHS-prescribed SAA information pamphlet and any other PREA related information the facility makes available to detainees.

§115.17 - Hiring and promotion decisions

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. ASF policy 10.1.1 states, "ASF is prohibited from hiring or promoting anyone (who will have direct contact with Detainees) who has engaged in Sexual Abuse in a prison, jail, holding Facility, community confinement Facility, Juvenile Facility or other institution who has been convicted of engaging in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. ASF shall conduct a background investigation to determine whether the candidate for hire is suitable for employment, including a criminal background record check and make its best efforts to contact prior institutional employers to obtain information on substantiated allegations of Sexual Abuse or any resignation pending investigation of an allegation of Sexual Abuse, prior to hiring new Employees. Background investigations, including criminal background records checks shall be repeated for all Employees at least every five years. Upon request, ASF shall submit written documentation showing the detailed elements of the Facility's background check for each Employee and the Facility's conclusions. ASF shall also impose upon Employees a continuing affirmative duty to disclose any such conduct as part of its hiring and promotional processes, and during annual performance reviews for current Employees. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate. Unless prohibited by law, ASF shall provide information on substantiated allegations of Sexual Abuse involving a former Employee upon receiving a request from an institutional employer for whom such Employee has applied to work." An interview with the HRM indicated before hiring a potential employee they must complete the Electronic Questionnaire for Investigation Processing (e-QIP) and must provide fingerprints. The HRM further indicated background checks are completed by the ICE Personnel Security Unit (PSU) and ICE determines suitability for hiring. In addition, the HRM indicated potential employees will fill out a Declaration for Federal Employment which states, "All your answers must be truthful and complete. A false

statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you or for firing you after you begin work" and all potential staff and volunteers are required to complete the DHS 6 Code of Federal Regulations Part 115 which asks potential staff/contractors all questions required by subsection (a) of the standard. The form requires the participant to sign the form which includes "I understand that a knowing and willful false response may result in a negative finding regarding my fitness as a contract employee supporting ICE. Furthermore, should my answers change at any time I understand I am responsible for immediately reporting the information to my Program Manager." An interview with the HRM further indicated the facility provides information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Utilizing the PSU Background Investigation for Employees and Contractors, the Auditor submitted 22 names to include 6 ICE staff, 5 IHSC medical staff, and 11 ASF staff to confirm background investigations. Documentation was provided to confirm all submitted names had completed a background check, had completed all required forms prior to being hired, and all five-year background checks had been completed as required. The Auditor reviewed two volunteer files and confirmed a background check had been completed and the volunteers had been asked about the prohibited behaviors prior to beginning services at the facility. In an interview with the HRM it was indicated no ASF staff had been promoted during the reporting period. However, an interview with the DFOD indicated one staff member had been promoted to a SDDO during the reporting period. An interview with the promoted SDDO confirmed he had not been asked about previous sexual misconduct in an interview or written application prior to his promotion. An interview with the facility PSA Compliance Manager, indicated the facility does not utilize the services of contractors.

Recommendation: The Auditor recommends the facility revise ASF 10.1.1 to include the facility will not enlist the services of volunteers who may have contact with detainees who has engaged in the behaviors prohibited by subsection (a) of the standard.

Corrective Action:

The Agency is not in compliance with subsections (a) and (b) of the standard. An interview with the DFOD indicated one staff member had been promoted to a SDDO during the reporting period. An interview with the SDDO confirmed he had not been asked about previous sexual misconduct in an interview or written application prior to his promotion. To become compliant the Agency must develop a process which requires employees offered promotions are directly asked about previous sexual misconduct related to sexual abuse in an interview or through a written application prior to being promoted as required by subsections (a) and (b) of the standard. In addition, if applicable, the Agency must provide the Auditor with documentation to confirm any ICE staff promoted during the CAP period was asked directly about previous misconduct related to sexual abuse either in an interview or by written application prior to being promoted.

§115.18 - Upgrades to facilities and technologies

Outcome: Not Applicable

Notes:

(a)(b): ASF policy 10.1.1 states, "ASF shall consider the effect any (new or upgrade) design, acquisition, substantial expansion, or modification of the physical plant might have on our ability to protect Detainees from Sexual Abuse. ASF shall also consider the effect any (new or upgrade) video monitoring system, electronic surveillance system or other monitoring system might have on our ability to protect Detainees from Sexual Abuse." The Auditor reviewed a memorandum to the file which states, "The Alexandria Staging Facility has not designed, modified, acquired, or expanded upon new or existing space, or installed or updated electronic monitoring systems since the last PREA Audit. Interviews with the facility PA and Auditor observations confirmed the facility has not designed, modified, acquired, or expanded upon new or existing space, or installed or updated electronic monitoring systems during the audit period; and therefore, standard 115.18 is not applicable.

Corrective Action:

No corrective action needed.

§115.21 - Evidence protocols and forensic medical examinations

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e): The Agency's Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per Policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." ASF policy 10.1.1.A, Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection states, "ASF is responsible for investigating allegations of Sexual Abuse and is required to follow uniform evidence protocols that maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." A review of ASF policy 10.1.1.A confirms the evidence protocol maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. An interview with a facility PSA Compliance Manager/Investigator confirmed the facility is responsible for conducting administrative investigations and would utilize ASF policy 10.1.1.A to maximize the potential for obtaining usable evidence. The facility PSA Compliance Manager/Investigator further indicated ASF policy 10.1.1.A was developed in coordination with DHS. In addition, the facility PSA Compliance Manager/Investigator indicated all allegations with a criminal nexus would be referred to the Rapides Parish Sheriff's Office (RPSO). The Auditor reviewed a Mutual Assistance Agreement (MAA) between ASF and the RPSO dated May 25, 2023, which remains in effect unless either party no longer agrees to its contents, which confirms RPSO has agreed to follow the requirements of §115.21 subsections (a)-(d). In addition, the Auditor reviewed an email from the facility Compliance Administrator to the Vice President of Survivor Services at Sexual Trauma Awareness and Response (STAR), which indicated STAR is small and does not have the capabilities to fulfill an MOU agreement with ASF; however, the email confirmed STAR provides advocacy (case management, crisis intervention, safety planning, accompaniments) to all survivors that reside in Avoyelles, Catahoula, Concordia, Grant, La Salle, Rapides, Vernon and Winn Parish to include any detainee survivor housed at ASF who presents at St. Francis Cabrini Hospital and requests an advocate during a forensic exam. Interviews with two RNs confirmed at no cost to the detainee victim, and only with the detainee's consent, the detainee victim would be transported to St. Francis Cabrini Hospital for a SANE exam. During the on-site audit, the Auditor placed a call to St. Francis Cabrini Hospital and confirmed the hospital has a Sexual Assault Nurse Examiner (SANE) Unit; however, the RN SANE Coordinator was not available to speak with the Auditor during the on-site audit to confirm what services would be offered to a detainee victim of sexual abuse.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours

of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." ASF policy 10.1.1-A states, "ASF shall have a policy in place to ensure that all allegations of Sexual Abuse are referred for investigation to a law enforcement Agency with legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. ASF shall document all referrals. The agency shall ensure that the agency and facility protocols required by paragraph (a) of this section, include a description of responsibilities of the agency, the facility, and any other investigating entities; and require the documentation and maintenance, for at least five years, of all reports and referrals of allegations of sexual abuse. GEO Corporate shall publish such corporate policy on its website. Each facility protocol shall ensure that all allegations are promptly reported to the agency as described in paragraphs (e) and (f) of this section, and, unless the allegation does not involve potentially criminal behavior, are promptly referred for investigation to an appropriate law enforcement agency with the legal authority to conduct criminal investigations. A facility may separately, and in addition to the above reports and referrals, conduct its own investigation. When a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director, and, if it is potentially criminal, referred to an appropriate law enforcement agency having jurisdiction for investigation. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director, and to the local government entity or contractor that owns or operates the facility. If the incident is potentially criminal, the facility shall ensure that it is promptly referred to an appropriate law enforcement agency having jurisdiction for investigation. The agency shall ensure that all allegations of detainee sexual abuse are promptly reported to the PSA Coordinator and to the appropriate offices within the agency and within DHS to ensure appropriate oversight of the investigation. The agency shall ensure that any alleged detainee victim of sexual abuse that is criminal in nature is provided timely access to U nonimmigrant status information." In addition, a review of ASF policy 10.1.1-A, confirms ASF policy 10.1.1-A includes a description of responsibilities of the Agency, the facility, and other investigating entities, requires the documentation and maintenance of all investigation reports be maintained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, and requires no matter what the circumstances, the files will be retained for no less than ten years. An interview with the PA indicated all allegations of sexual abuse are reported to the AFOD, the Joint Intake Center (JIC), and the OPR. An interview with the facility PSA Compliance Manager/Investigator indicated all allegations of sexual abuse are investigated at the facility and when the facility receives an allegation of sexual abuse RPSO is notified immediately. An interview with the facility PSA Compliance Manager/Investigator further indicated an administrative investigation would begin once the RPSO has decided if a criminal investigation will continue or if they decline to investigate. The Auditor reviewed one sexual abuse allegation investigation file and confirmed notification had been made to RPSO.

Corrective Action:

No corrective action needed.

§115.31 - Staff training

Outcome: Exceeds Standard

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "All Employees, Contractors and Volunteers shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program. See Section F for Volunteer requirements and Section G for Contractor requirements. ASF shall train all Employees who may have contact with Detainees on: 1) Its zero tolerance policy for Sexual Abuse and Assault; 2) How to fulfill their responsibilities under agency Sexual Abuse and Assault prevention, detection, reporting and response policies and Procedures, to include procedures for reporting knowledge or suspicions of Sexual Abuse; 3) Recognition of situations where Sexual Abuse may occur; 4) The right of Detainees and Employees to be free from Sexual Abuse, and from retaliation

for reporting Sexual Abuse and Assault; 5) Definitions and examples of prohibited and illegal sexual behavior; 6) Recognition of physical, behavioral and emotional signs of Sexual Abuse, and methods of preventing and responding to such occurrences; 7) How to detect and respond to signs of threatened and actual Sexual Abuse; 8) How to avoid inappropriate relationships with Detainees; 9) How to communicate effectively and professionally with Detainees, including LGBTI or Gender Non-conforming Detainees; and, 10) The requirement to limit reporting of Sexual Abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. PREA refresher training shall be conducted each year thereafter for all Employees. Refresher training shall include updates to Sexual Abuse and Assault policies. Employees shall document through signature or electronic verification that they understand the training they have received." The Auditor reviewed the Sexual Abuse and Assault Prevention and Intervention (PREA) 2017 In-Service training curriculum and confirmed all elements required by subsection (a) are included in the facility PREA training. Interviews with three random DOs indicated they were knowledgeable regarding the facility PREA policies to include the requirement all staff must complete training during their annual in-service training. The Auditor reviewed 22 training files, to include 6 ICE staff, 5 IHSC medical staff, and 11 ASF staff and confirmed all had received PREA training in 2022 and 2023; and therefore, the Auditor finds the facility exceeds the standard's required to provide PREA refresher information every two years. The facility does not utilize the services of staff contractors who have continuous contact with detainees.

Corrective Action:

No corrective action needed.

§115.32 - Other training

Outcome: Exceeds Standard

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "All Employees, Contractors and Volunteers shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program. ASF shall ensure that all Volunteers who have contact with Detainees are trained on their responsibilities under GEO's Sexual Abuse and Assault prevention, detection, and response policies and procedures. The level and type of training provided to Volunteers shall be based on the services they provide and the level of contact they have with Detainees, but all Volunteers who have contact with Detainees shall be notified of GEO's and the facility's zero-tolerance policies regarding Sexual Abuse and informed how to report such incidents. Volunteers who have contact with Detainees shall receive annual PREA refresher training. Volunteers shall document through signature or electronic verification that they understand the training they have received." The Auditor reviewed the ICE Prison Rape Elimination Act (PREA) Training for Contractors and Volunteers curriculum and confirmed it notifies both volunteers and "other" contractors of the ICE and the facility's zero-tolerance policies and how to report an allegation of sexual abuse. An interview with the PSA Compliance Manager indicated that all volunteers are required to complete PREA training every year. The Auditor reviewed two volunteer files and confirmed both volunteers had received the ICE PREA Training for Contractors and Volunteers. The facility currently does not have "other" contractors who provide services at ASF.

Corrective Action:

No corrective action needed.

§115.33 - Detainee Education

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(f): ASF policy 10.1.1 states, "During the intake process, ASF shall ensure that the Detainee orientation program notifies and informs Detainees about the Company's zero tolerance policy regarding all forms of Sexual Abuse and Assault and includes instruction on: 1) Prevention and intervention strategies; 2) Definitions and examples of Detainee-on-Detainee Sexual Abuse, Employee on Detainee Sexual Abuse and coercive Sexual Activity; 3) Explanation of methods for reporting Sexual Abuse, including to any Employee, including an

Employee other than immediate point-of contact line officer (i.e. the PSA Compliance Manager or Mental Health staff), the DHS Office of Inspector General, and the Joint Intake Center; 4) Information about self-protection and indicators of Sexual Abuse; 5) Prohibition against retaliation, including an explanation that reporting Sexual Abuse shall not negatively impact the Detainee's immigration proceedings; and, 6) The right of a Detainee who has been subjected to Sexual Abuse to receive treatment and counseling. At ASF, education shall be provided in formats accessible to all Detainees, including those are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to Detainees who have limited reading skills. ASF shall maintain documentation of Detainee participation in the intake process orientation which shall be retained in their individual files." During the on-site audit, the Auditor reviewed the ICE National Detainee Handbook and confirmed the ICE National Detainee Handbook includes information on how to report an allegation of sexual abuse. In addition, during the on-site audit, the Auditor observed an English and Spanish version of the ICE National Detainee Handbook posted in each housing unit; however, the Auditor did not observe a supply of the ICE National Detainee Handbook in Intake process, available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. In an interview with two Processing Officers, it was confirmed the two Processing Officers could not articulate how detainees would receive the PREA information included in the ICE National Detainee Handbook during the Intake process. During the on-site audit, the Auditor partially observed the orientation process due to the detainee's late arrival and confirmed once the detainees had their bed assignments, they were instructed to sit in the common area of the housing unit and watch the PREA orientation video available in English, Spanish, and closed captioning, for detainees who were deaf or hard of hearing. However, in an interview with two Processing Officers it was confirmed the facility had the capability to print a transcription of the video, and translate it into other languages, if needed. Interviews with two Processing Officers, indicated during Intake processing, the detainees watch the video, are provided the facility local supplement handbook, and the detainees are asked to sign the facility Orientation Sign-In Sheet, confirming receipt of the video and the handbook. The Auditor reviewed the Orientation Sign-in Sheet, available in English and Spanish and confirmed the sign-in sheet states, "I have reviewed the Orientation Video and the PREA-What You Need to Know video and I have been given the opportunity to ask questions. I have received the local supplement Resident Handbook and I understand the policies and procedures of the Alexandria Staging Facility. I have been advised the Orientation/Education Station is accessible in the housing unit which contains the ICE National Detainee Handbook and additional SAAPI information. I have been given the ICE Sexual Abuse and Assault Awareness pamphlet in my preferred language. I have been given instructions on how to use the telephone and I understand the first call is provided to me as a courtesy." In addition, the Auditor reviewed the facility PREA Risk Assessment and confirmed it includes "Receipt of DHS Pamphlet" and requires the detainee signature. During interviews with two Processing Officers, it was indicated if a detainee spoke a language other than English or Spanish, the forms would be read to them with the use of the facility language line. The Auditor reviewed the facility's September 2023 Language line bill and confirmed the language line had been utilized 445 times during Intake processing: however, an interview with two Processing Officers confirmed the two Processing Officers could not produce the DHS-prescribed SAA Information pamphlet and could only produce a copy of the ICE National Detainee Handbook in English only; and therefore, the Auditor could not confirm the language line was utilize to provide the detainee PREA orientation. The Auditor interviewed 23 detainees to include 5 detainees who had gone through the intake process the evening prior to the interview and each detainee had been given the opportunity to watch the PREA video; however, after having traveled all day, they were too exhausted; and therefore, did not watch the video. Interviews with five detainees who had gone through the intake process the night before further confirmed they had not been given any written material to include the facility handbook, the ICE National Detainee Handbook, or the DHS-prescribed SAA Information pamphlet; and therefore, the Auditor had each detainee, review their signed PREA Risk Assessment and the signed Orientation Sign-In Sheet, and inquired why the five detainees had signed the documents if they had not received the PREA information. Each detainee processed the night before the interview confirmed the Processing Officer had instructed them to sign in three separate places and they followed the officer's direction even though they were not given an opportunity to read the document. In addition, each detainee interviewed who was

processed the evening prior to the interview confirmed they did not read the PREA Risk Assessment and when shown the document, which indicated they had received the DHS SAAPI Pamphlet, they each confirmed they thought they were signing an acknowledgement that they had completed the assessment and not that they had received written material. In interviews with the additional 18 detainees, it was indicated they were not given any written documentation, during Intake process; however, several detainees reported immediately prior to the Auditor's interview, the housing unit officers had yelled out, asking if anyone wanted a copy of the facility handbook. The Auditor reviewed 18 detainee files and confirmed all detainees had signed the PREA Risk Assessment and the Orientation Sign-In Sheet; however, based on detainee interviews and Auditor observation during the orientation process the Auditor could not confirm what PREA orientation, if any, was provided to the detainees during the intake process.

(d)(e): ASF policy 10.1.1 states, "ASF shall post on all housing unit bulletin boards the following notices: 1) The DHS-prescribed sexual assault awareness notice; 2) The name of the PSA Compliance Manager; and 3) The name of local organizations that can assist Detainees who have been victims of Sexual Abuse. Facilities shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet. Detainee notification, orientation and instruction must be in a language or manner that the detainee understands. The facility shall maintain documentation of detainee participation in the instruction session. The information is communicated orally and in writing, in a language clearly understood by the detainee, upon arrival at the facility." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, which contained the name of the facility PSA Compliance Manager, and a flyer RAINN, which operates the National Sexual Assault Hotline, posted in all housing units. However, the Auditor could not confirm the DHS-prescribed SAA Information pamphlet is available or distributed to the detainees during the intake process. In addition, interviews with two Processing Officers and 23 detainees confirmed neither the officers or the detainees were aware of the DHS-prescribed SAA Information pamphlet or the information it contained.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed an English and Spanish version of the ICE National Detainee Handbook posted in each housing unit; however, the Auditor did not observe a supply of the ICE National Detainee Handbook in Intake process, available in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. In an interview with two Processing Officers, it was confirmed the two Processing Officers could not articulate how detainees would receive the PREA information included in the ICE National Detainee Handbook during the Intake process. In addition, during the on-site audit the Auditor did not observe copies of the DHS-prescribed SAA Information pamphlet available in 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian in Intake processing. The Auditor reviewed the facility's September 2023 Language line bill and confirmed, the language line had been utilized 445 times during intake; however, while in the Processing office, the Auditor requested each Processing Officer, to show her the DHS-prescribed SAA Information pamphlets and the ICE National Detainee Handbooks and the two Processing Officers could not produce the DHS-Prescribed SAA Information pamphlet and could only locate a copy of the ICE National Detainee Handbook in English. The Auditor interviewed five detainees who had been processed the evening before the interview and confirmed each detainee had not been given any written material to include the facility handbook, the ICE National Detainee Handbook, or the DHS-prescribed SAA Information pamphlet; and therefore, the Auditor had each detainee, review their signed PREA Risk Assessment and the signed Orientation Sign-In Sheet, and inquired why the five detainees had signed the documents if they had not received the PREA information. In addition, in an interview with five detainees processed the night before the interview confirmed the Processing Officer had instructed them to sign in three separate places and they followed the officer's direction even though they were not given an opportunity to read the document. In an interview with five detainees processed the night before the interview confirmed they did not read the PREA Risk Assessment and when shown the document, which indicated they had received the DHS-prescribed SAA Information Pamphlet,

they each confirmed they thought they were signing an acknowledgement confirming they had completed the assessment and not that they had received written material. In interviews with an additional 18 detainees, it was indicated they were not given any written documentation, during Intake process; however, several detainees reported immediately prior to the Auditor's interview, the housing unit officers had yelled out, asking if anyone wanted a copy of the facility handbook. The Auditor reviewed 18 detainee files and confirmed all detainees had signed the PREA Risk Assessment and the Orientation Sign-In Sheet; however, based on detainee interviews and Auditor observation during the orientation process the Auditor could not confirm what PREA orientation, if any, was provided to the detainees during the intake process. To become compliant, the facility must implement an orientation program during the intake process which notifies and informs the detainee about the Agency and the facility zero-tolerance policies and includes instructions on all elements required by subsection (a) of the standard. The orientation program shall include notification, orientation, and instruction in formats accessible to all detainees, including those who are LEP, deaf or hard of hearing, blind or have limited site or otherwise disabled, as well as those who have limited reading skills. Once the orientation program has been implemented the facility must submit documentation which confirms all Processing Officers have received training on the updated practice. In addition, the facility must submit 15 detainee files to include, if applicable detainees whose preferred language is other than English or Spanish and/or are deaf or hard of hearing, blind or have limited site or otherwise disabled, as well as those who have limited reading skills during the CAP period to confirm detainees receive orientation during intake in a manner all detainees can understand to include all elements of subsection (a) of the standard. The facility is not in compliance with subsection (e) of the standard. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, which contained the name of the facility PSA Compliance Manager and a flyer for RAINN, which operates the National Sexual Assault Hotline, posted in all housing units. However, the Auditor could not confirm that the DHS-prescribed SAA Information pamphlet is available or distributed to the detainees as required by subsection (e) of the standard. In addition, interviews with two Processing Officers and 23 detainees confirmed neither were aware of the DHS-prescribed SAA Information pamphlet or the information it contained. To become complaint, the facility must submit documentation which confirms the DHS-prescribed SAA Information pamphlet available in the 15 most prevalent languages encountered by ICE, (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian is distributed to all detainees during intake processing in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all Processing Officers have received training on the updated practice. In addition, the facility must submit 15 detainee files to include, if applicable detainees whose preferred language is other than English or Spanish and/or are deaf or hard of hearing, blind or have limited site or otherwise disabled, as well as those who have limited reading skills to confirm the detainee has received the DHS-prescribed SAA Information pamphlet in a manner they can understand during the CAP period.

§115.34 - Specialized training: Investigations

Outcome: Meets Standard

Notes:

(a)(b): ASF policy 10.1.1 states, "ASF investigators shall be trained in conducting investigations on Sexual Abuse and effective cross-agency coordination. All investigations into alleged Sexual Abuse must be conducted by qualified investigators. Investigators shall receive this specialized training in addition to the general training mandated for Employees in Section E (1). ASF shall maintain documentation of this specialized training." An interview with the PSA Compliance Manager/Investigator indicated she has completed the National PREA Resource Center's PREA Specialized Training: Investigating Sexual Abuse in a Correctional Setting. The Auditor reviewed the National PREA Resource Center's PREA Specialized Training: Investigating Sexual Abuse in a Correctional Setting training curriculum and confirmed the curriculum includes all elements required by the standard. In addition, the Auditor reviewed a Certificate of Completion for the course submitted by the PSA Compliance Manager/Investigator, and training rosters, to confirm the PSA Compliance Manager/Investigator completed general PREA training as required by §115.31 in addition to the specialized training required by subsections (a) and (b) of the standard.

Corrective Action:

No corrective action needed.

§115.35 - Specialized training: Medical and mental health care

Outcome: Meets Standard

Notes:

(a)(b)(c): IHSC policy 03-01 Sexual Abuse and Assault Prevention and Intervention states, "All IHSC staff receive training on the Sexual Abuse and Assault Prevention and Intervention (SAAPI) directive, PREA standards, and response protocol during initial orientation and annually thereafter throughout their employment with IHSC. Training includes Definition and examples of prohibited and illegal sexual behavior, recognizing situations where sexual abuse may occur. Detection and treatment of physically or sexually abused and assaulted detainee victims in ICE custody. Appropriate interventions when an incident occurs. Description of how to respond effectively and professionally to detainee victims of sexual abuse and assault, recognizing physical, behavioral, and emotional signs of sexual abuse. Discussion of how to communicate effectively and professionally to bisexual, transgender, intersex (LGBTI), or gender nonconforming detainee victims. Actions that will assist detainee victims to safeguard physical evidence of sexual abuse and assault. Steps for reporting allegations or suspicions of sexual abuse and assault. IHSC staff will not suffer retaliation for reporting abuse or assaults. Information for security staff on how to conduct "cross gender" pat down searches and searches of transgender and intersex detainees in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. How to identify and protect physical evidence with detainee victims, including lesbians and gays, and how to protect physical evidence." ASF policy 10.1.1 states, "IHSC shall train all full-time and part-time Medical and Mental Health Care Practitioners who work regularly in its Facilities on certain topic areas, including detecting signs of Sexual Abuse and Assault, preserving physical evidence of Sexual Abuse, responding professionally to victims of Sexual Abuse and proper reporting of allegations or suspicions of Sexual Abuse and Assault. Medical and Mental Health Care Practitioners shall receive this specialized training in addition to the general training mandated for Employees in Section E (1) or Contractors in Section G (1) depending upon their status at the Facility. Facility medical staff shall not participate in sexual assault forensic medical examinations or evidence gathering. Forensic examinations shall be performed by a Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE). An offsite Qualified Medical Practitioner may perform the examination if a SAFE or SANE is not available. IHSC shall maintain documentation of this specialized training." The Auditor reviewed the IHSC Sexual Abuse and Assault Prevention and Intervention training curriculum and confirmed all training elements are included. Interviews with two IHSC RNs and one LCSW confirmed medical and mental health have received specialized training. In addition, the Auditor reviewed medical and mental health training records and confirmed medical and mental health staff have received general PREA training as required by §115.31. An interview with the DFOD confirmed ASF policy 10.1.1 has been submitted and approved by the Agency.

Corrective Action:

No corrective action needed.

§115.41 - Assessment for risk of victimization and abusiveness

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(g): ASF policy 10.1.1 states, "All Detainees shall be assessed during intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house Detainees to prevent Sexual Abuse, taking necessary steps to mitigate any such danger. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly. The initial classification process and initial housing assignment shall be completed within 12 hours of admission to the Facility. ASF shall also consider, to the extent that the information is available, the following criteria to assess Detainees for risk of sexual victimization to be completed by Officers: 1) Mental, physical or developmental disability; 2) Age; 3) Physical build and appearance;

4) Previous incarceration or detained; 5) Nature of criminal history; 6) Prior convictions for sex offenses against an adult or child; 7) Whether Detainee self-identified as LGBTI or Gender Nonconforming; 8) Whether Detainee self-identified as having previously experienced sexual victimization; and, 9) Own concerns about his/her physical safety. e. The intake screening shall also consider prior acts of Sexual Abuse, prior convictions for violent offenses, and history of prior institutional violence or Sexual Abuse, as known to the Facility, in assessing the risk of being sexually abusive." The Auditor reviewed the PREA Risk Assessment tool and confirmed it includes all elements required by subsections (c) and (d) of the standard. During the on-site audit, the Auditor partially observed the intake process and confirmed the housing unit assignment of each detainee was already known by observing detainees classified as high-level being lined up outside the high-level housing unit and then instructed to enter the unit and find themselves a cell with an empty bed. While in the housing unit the Auditor informally interviewed several detainees who confirmed they had to pick a bed which already had one detainee in the cell. In interviews with two Processing Officers, it was indicated detainees are taken into the Processing Officer's office located inside the housing unit which is shared with medical staff divided halfway with a partition. Interviews with two Processing Officers further indicated detainees are asked the questions on the initial risk assessment while medical staff are conducting their initial assessment of other detainees and if a detainee discloses, he has experienced sexual abuse or has been sexually abusive the Processing Officer will notify the Intake supervisor who will come and sign the assessment. The Auditor interviewed 23 detainees to include 5 detainees who had gone through the intake process the evening prior to the interviews and confirmed the 5 detainees who were processed the evening prior to the interview had been asked the initial risk assessment questions on the initial risk assessment; however, two of the detainees indicated they had been woken up in the middle of the night to answer the questions and the remaining three detainees confirmed they had been asked the initial risk assessment questions just prior to the Auditor's visit to the unit the following morning. During the on-site Audit the Auditor observed the facility maintained the completed risk assessments in a locked cabinet located in the Intake Supervisor's office; however, interviews with the remaining 18 detainees confirmed although they were asked the initial risk assessment questions, they had lied in answering them as there were other detainees in the room completing medical assessment and they did not want the other detainees to know their sexual preference or if they had experienced sexual abuse, so they indicated "no" when asked. Based on this information, the Auditor could not confirm the facility has implemented appropriate controls on the dissemination of responses to the initial risk assessment to ensure sensitive information provided is not exploited to the detainees' detriment by other detainees. Two of the detainees shared with the Auditor they were gay and had previously experienced sexual abuse within their lifetime which the Auditor promptly reported to facility administration. The Auditor reviewed 18 detainee files and confirmed an assessment had been completed; however, the Auditor could not confirm the initial risk assessment was being utilized to determine a detainee's risk of victimization or risk of being sexually abusive. During the on-site Audit the Auditor confirmed the facility has implemented appropriate controls on the dissemination of responses to the initial risk assessment by maintaining the completed risk assessments in a locked cabinet located in the Intake Supervisor's office.

(e)(f): ASF policy 10.1.1 states, "ASF shall ensure that between 60 and 90 days from the initial assessment at the Facility, staff shall reassess each Detainee's risk for victimization or abusiveness using the PREA Vulnerability Reassessment Questionnaire which is to be completed by Case Managers. The PREA Risk Assessment form is completed initially upon arrival. At any point after the initial intake screening, a Detainee shall be reassessed for risk of victimization or abusiveness when warranted based upon the receipt of additional, relevant information or following an incident or abuse or victimization. Disciplining Detainees for refusing to answer or not providing complete information in response to certain screening questions is prohibited. ASF shall implement appropriate controls on dissemination of responses to questions asked related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by Employees or other Detainees. Sensitive information shall be limited to need-to-know Employees only for the purpose of treatment, programming, housing and security and management decisions." An interview with the Intake Supervisor confirmed detainees are not disciplined for refusing to answer the questions or for not disclosing complete information. The Auditor reviewed a memorandum to the file which states, "The Alexandria Staging Facility has not had a 60–90-day reassessment

required in the audit period." Interviews with the facility PA and PSA Compliance Manager confirmed they have not had a detainee housed at the facility long enough to complete a 60-day reassessment. The Auditor reviewed the one sexual abuse allegation investigation file and confirmed the detainee victim had departed from the facility the following day; and therefore, a reassessment could not be conducted.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (g) of the standard. During the on-site audit, the Auditor partially observed the intake process and confirmed the housing unit assignment of each detainee was already known by observing detainees classified as high-level being lined up outside the high-level housing unit and then instructed to enter the unit and find themselves a cell with an empty bed. While on the housing unit the Auditor informally interviewed several detainees who confirmed they had to pick a bed which already had one detainee in the cell. The Auditor interviewed 23 detainees to include 5 detainees who had gone through the intake process the evening prior to the interview and confirmed the five detainees who were processed the evening prior to the interview had been asked the initial risk assessment questions on the initial risk assessment; however, two of the detainees indicated they had been woken up in the middle of the night to answer the questions and the remaining three detainees confirmed they had been asked the initial risk assessment questions just prior to the Auditor's visit to the unit the following morning; and therefore, the Auditor could not confirm the facility assesses detainees upon intake to identify those likely to be sexual aggressors or sexual abuse victims to house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger or that initial classification and housing is completed within 12 hours of admission to the facility. In addition, during the on-site Audit the Auditor observed the facility maintained the completed risk assessments in a locked cabinet located in the Intake Supervisor's office; however, interviews with the remaining 18 detainees confirmed although they were asked the initial risk assessment questions, they had lied in answering them as there were other detainees in the room completing medical assessments and they did not want the other detainees to know their sexual preference or if they had experienced sexual abuse, so they indicated "no" when asked; and therefore, the Auditor could not confirm the facility has implemented appropriate controls on the dissemination of responses to the initial risk assessment to ensure sensitive information provided is not exploited to the detainees detriment by other detainees. To become compliant, the facility must assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and must house all detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger to include a practice to keep newly arrived detainees separate from the general population until the detainee is classified and may be housed accordingly. In addition, the facility must ensure initial classification and housing assignment is completed within 12 hours of admission into the facility. Once implemented the facility must submit documentation which confirms all Processing Officers have received training on the updated practices. In addition, the facility must implement a practice to ensure appropriate controls on the dissemination of responses to the initial risk assessment are in place, so sensitive information provided is not exploited to the detainee's detriment by other detainees. The facility must submit 20 detainee files which confirm compliance with subsections (a) and (b) of the standard that occur during the CAP period.

§115.42 - Use of assessment information

Outcome: Does Not Meet Standard

Notes:

(a): ASF policy 10.1.1 states, "Screening information from standard Section C (1) shall be used to inform assignment of Detainees to housing, recreation, and other activities. ASF shall make individualized determinations about how to ensure the safety of each Detainee." During the on-site audit, the Auditor partially observed the intake process. The facility had received over 150 detainees, at one time, and at approximately 4:00 p.m. The detainees were brought into the facility and seated in the airport seating area. The Auditor observed and confirmed the housing unit assignment of the detainees were already known. Detainees classified as high-level were called and lined up outside the housing unit. The detainees were uncuffed and pat-searched, given bedding and shower shoes, and instructed to enter the unit and find themselves an empty bed within the cells. The high-level housing unit has two-person cells. Informal interviews with several detainees indicated that they had to pick a bed that already had one detainee in the cell. Once all of the high-level detainees had chosen

their bed, they were instructed to sit in the common area of the housing unit and watch the orientation video. The Auditor had left the facility for the day before the end of the video; however, the Auditor interviewed two Processing Officers, and was walked through the remainder of the process. Detainees are taken into the Processing Officer's office which is located inside the housing unit. The processing office is shared with medical staff and divided halfway with a partition. Detainees are asked the questions on the risk assessment while medical staff are conducting their initial assessment of other detainees. If a detainee discloses, he has experienced sexual abuse or has been sexually abusive, the Processing Officer will notify the Intake supervisor, who will come and sign the assessment. The following morning, the Auditor interviewed five detainees. Each detainee had been asked the questions on the assessments, two of the detainees reported that they had been woken up in the middle of the night to answer the questions. The other three detainees reported that they had been asked the questions, just prior to my arrival in the unit, which was after 9:00 a.m.; and therefore, the Auditor could not confirm the facility utilizes the information from the initial risk assessment under 115.41 to inform assignment of detainees to housing. Through-out the on-site audit, the Auditor interviewed a total of twenty-three detainees, which includes the five stated above. Several detainees reported that although they were asked the questions, they admitted to the Auditor that they had lied in answering them. When asked to explain, they indicated that the questions are personal in nature, there were other detainees in the room, completing a medical assessment, one detainee indicated that there were three other detainees in the room when he was asked the questions. Each detainee stated they could hear the other detainees answering the medical questions and did not want the detainee population to know their sexual preference or if they had been previously sexually abused, so they indicated "no" when asked. Two of the detainees shared with the Auditor, they were gay and had experienced sexual abuse in their lifetime. The Auditor reviewed 18 detainee files and confirmed an assessment had been completed. In an interview with the facility PA, it was confirmed detainees are only at the facility short term until their flights are arranged; and therefore, screening for recreation and other activities, and volunteer programing does not apply.

(b)(c): ASF policy 10.1.1 states, "When making assessments and housing decisions for Transgender and Intersex Detainees, ASF shall consider the Detainee's gender self-identification and an assessment of the effects of placement on the Detainee's health and safety. A Medical or Mental Health Practitioner shall be consulted as soon as practicable on these assessments and placement decisions which shall not be based solely on the identity documents or physical anatomy of the Detainee. The Detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. Housing and programming assignments for each Transgender and Intersex Detainee shall be reassessed at least twice each year to determine any threats to safety experienced by the Detainee. This assessment is completed by the PREA PSA Compliance Manager. Serious consideration shall be given to the individual's own views with respect to his/her own safety. When operationally feasible, Transgender and Intersex Detainees shall be given an opportunity to shower separately from other Detainees." Interviews with the PSA Compliance Manager, the Intake Supervisor and three random detention officers confirmed the facility does not house transgender detainees. Known transgender detainees are not brought to the facility and if a detainee indicates they are a transgender detainee, the detainee would be transferred to another ICE facility within close proximity.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. During the on-site audit, the Auditor partially observed the intake process. The facility had received over 150 detainees, at one time, and at approximately 4:00 p.m. The detainees were brought into the facility and seated in the airport seating area. The Auditor observed and confirmed the housing unit assignment of the detainees were already known. Detainees classified as high-level were called and lined up outside the housing unit. The detainees were uncuffed and pat-searched, given bedding and shower shoes, and instructed to enter the unit and find themselves an empty bed within the cells. The high-level housing unit, have two-person cells. Informal interviews with several detainees, indicated that they had to pick a bed, that already had one detainee in the cell. Once all of the high-level detainees had chosen their bed, they were instructed to sit in the common area of the housing unit and watch the orientation video. The Auditor had left the facility for the day before the end of the video; however, the Auditor interviewed two Processing Officers, and was walked through the remained of the process. Detainees are taken

into the Processing Officer's office which is located inside the housing unit. The processing office is shared with medical staff and divided halfway with a partition. Detainees are asked the questions on the risk assessment while medical staff are conducting their initial assessment of other detainees. If a detainee discloses, he has experienced sexual abuse or has been sexually abusive, the Processing Officer will notify the Intake supervisor, who will come and sign the assessment. The following morning, the Auditor interviewed five detainees. Each detainee had been asked the questions on the assessments, two of the detainees reported that they had been woken up in the middle of the night to answer the questions. The other three detainees reported that they had been asked the questions, just prior to my arrival in the unit, which was after 9:00 a.m. Through-out the on-site audit, the Auditor interviewed a total of twenty-three detainees, which includes the five stated above. Several detainees reported that although they were asked the questions, they admitted to the Auditor that they had lied in answering them. When asked to explain, they indicated that the questions are personal in nature, there were other detainees in the room, completing a medical assessment, one detainee indicated that there were three other detainees in the room when he was asked the questions. Each detainee stated they could hear the other detainees answering the medical questions and did not want the detainee population to know their sexual preference or if they had been previously sexually abused, so they indicated "no" when asked. Two of the detainees shared with the Auditor, they were gay and had experienced sexual abuse in their lifetime. The Auditor reviewed 18 detainee files and confirmed an assessment had been completed. To become compliant, during intake, the facility shall assess all detainees to identify those likely to be sexual aggressors or sexual abuse victims and shall use the information to inform housing. The facility shall provide at least 20 detainee files to include the date and time of admission to ASF, the date, and time the initial risk assessment is completed, and the date and time, of the detainees initial housing assignment.

§115.43 - Protective Custody

Outcome: Meets Standard

Notes:

(a): ASF policy 10.1.1 states, "ASF shall develop and follow written procedures governing the management of its Disruptive Detainee Management Housing (DDMH). ASF does not have a Special Management Unit." Interviews with the facility PA, PSA Compliance Manager, and Auditor observations confirmed the facility physical plant does not allow for a segregation unit or a protective custody unit. In addition, in an interview with the facility PA it was indicated disruptive cells would only be utilized for detainees who display disruptive behaviors and not for a detainee who is vulnerable to sexual abuse. Therefore, subsection (a) of the standard is not applicable.

(b)(c)(e): In an interview with the facility PA, it was indicated the facility would temporarily restrict detainees vulnerable to sexual abuse from the general population by confining them to a cell in their housing unit. An interview with the facility PA further indicated use of cell restriction to protect detainees vulnerable to sexual abuse or assault would be only until the Agency could arrange a transfer to another facility which would usually occur within hours of placement. In addition, in an interview with the facility PA it was indicated the FOD would immediately be notified to arrange transport and the placement would occur only after reasonable efforts have been made to provide appropriate housing, shall be made for the least amount of time practicable, and when no other viable housing option exists. An interview with the facility PA further indicated if placement lasted longer than a few hours the detainee would have access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable.

(d): An interview with the facility PA further indicated use of cell restriction to protect detainees vulnerable to sexual abuse or assault would be only until the Agency could arrange a transfer to another facility which would usually occur within hours of placement; and therefore, subsection (d) of the standard does not apply.

Corrective Action:

No corrective action needed.

§115.51 - Detainee Reporting

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "ASF shall provide multiple ways for Detainees to privately report Sexual Abuse and Assault, retaliation for reporting Sexual Abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. ASF shall provide contact information to Detainees for relevant consular officials and officials, the DHS Office of Inspector General or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents. ASF shall provide Detainees contact information on how to report Sexual Abuse or Assault to a public or private entity or office that is not part of GEO (i.e. contracting agency ICE) and that is able to receive and immediately forward Detainee reports of Sexual Abuse to Facility or GEO officials, allowing the Detainee to remain anonymous upon request. ASF shall provide Detainees contact information on how to report Sexual Abuse or Assault to the Facility PSA Compliance Manager. Employees shall accept reports made verbally, in writing, anonymously and from third parties and shall promptly document any verbal reports. Employees reporting Sexual Abuse shall be afforded the opportunity to report such information to the Chief of Security or upper-level executive privately if requested." The Auditor observed information in English and Spanish that advised detainee's how to contact their consular official, the DHS OIG, and DRIL, and the designated facility PREA Hotline to confidentially and if desired anonymously report an incident of sexual abuse posted in all common areas of the facility, including in close proximity to the detainee telephones. Interviews with PSA Compliance Manager and three detention officers indicated detainees are provided multiple ways to report sexual abuse, retaliation and any staff neglect of their responsibilities that may have contributed to an incident of sexual abuse. In addition, the three detention officers indicated that all reports received verbally, in writing, anonymously and from third parties must be promptly reported and documented. Detainees can report to the facility utilizing the PREA Hotline from the detainee phones. During the on-site audit, the Auditor tested all phone numbers provided to the detainees. Phone calls made to DHS OIG, DRIL and the JIC were completed and confirmed to be in good working order. Phone calls made to RAINN, the facility PREA Hotline and the consular officials, were not properly working. The facility immediately began to look into the issue and the facility provided email documentation to indicate the issue had been fixed. Prior to the Auditor concluding the on-site audit, the Auditor confirmed the numbers were in good working order. However, the Auditor reviewed one investigative file which indicated on March 1, 2022, a detainee family member had contacted OIG in reference to a report of sexual abuse. The facility provided the Auditor with email documentation, that indicated the OIG office did not immediately report the allegation to the Agency or the facility. OIG reported the allegation on March 15, 2022. An investigation was immediately started; however, the victim detainee had been removed from the facility. In addition, during the investigation, it was determined that the victim detainee had notified a staff member of the allegation, prior to the report being made to OIG. The staff member failed to report the allegation.

Corrective Action:

The facility is not in compliance with subsections (a)(b) and (c) of the standard. The Auditor reviewed one investigative file which indicated on March 1, 2022, a detainee family member had contacted OIG in reference to a report of sexual abuse. The facility provided the Auditor with email documentation that indicated the OIG office did not immediately report the allegation to the Agency or the facility. OIG reported the allegation on March 15, 2022. An investigation was immediately started; however, the victim detainee had been removed from the facility. In addition, during the investigation, it was determined that the victim detainee had notified a staff member of the allegation prior to the report being made to OIG. The staff member failed to report the allegation. To become compliant, the Agency shall review all documentation available regarding this allegation, to determine the reasoning behind the outside agency's failure to immediately report the allegation to the Agency or facility. The Agency shall implement any corrective action needed to ensure the outside agency is able to immediately forward all allegations received on behalf of a detainee in their care. Documentation of the review and any corrective action implemented shall be forwarded to the Auditor. The facility shall re-train all staff on their responsibilities to immediately report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse and all reports received must be documented. Documentation of the training curriculum

and staff participation in the training shall be provided to the Auditor. In addition, if applicable, the facility shall forward any investigations of detainee allegations of sexual abuse to the Auditor that are completed during the corrective action phase of the audit.

§115.52 - Grievances

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): ASF Revised Supplement to the National Detainee Handbook states, "An emergency grievance involves an immediate threat to a detainee's welfare or safety. The facility shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. All ASF staff are trained to appropriately respond to emergency grievances in an expeditious manner. Once the receiving employee approached by a detainee determines that the detainee is in fact raising an issue requiring urgent attention, emergency grievance procedures shall apply, and the employee will act immediately. Translation Services will be available upon request. The protocol for emergency grievance procedures shall bring the matter to the attention of the Facility Project Administrator, even if it is later determined that it is not a true emergency, and the grievance is subsequently routed through normal, non-emergency channels. Detainees may present an emergency grievance directly to the Shift Supervisor who will in turn implement the emergency grievance procedures and notify the Facility Project Administrator." During the on-site audit, the Auditor observed grievance forms and the grievance boxes in areas accessible to the detainees. An interview with the facility GO indicated grievance forms and locked grievance boxes are located in common areas of the facility and grievances are picked up daily. An interview with the GO further indicated no time limits are imposed on grievances alleging sexual abuse and detainees can request the assistance of another detainee, staff, family, legal representative, or any other person. In addition, in an interview with the GO it was indicated all grievances related to sexual abuse are considered emergency grievances and for all grievances related to sexual abuse the detainee would be issued notification within five days indicating the grievance is closed and referred to the PREA Investigator for investigation. An interview with the GO further confirmed if a detainee were to appeal the response to the grievance the appeal would be answered within five days and once the investigation is concluded the grievance, the investigation report, and the grievance response would be forwarded to the ICE AFOD. The Auditor reviewed the PREA allegation spreadsheet and confirmed there have been no sexual abuse allegations reported through the grievance system during the Audit period.

Corrective Action:

No corrective action needed.

§115.53 - Detainee access to outside confidential support services

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): ASF policy 10.1.1 states, "ASF shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of Sexual Abuse perpetrators to most appropriately address victim's needs. ASF shall make available to Detainees information about local organizations that can assist Detainees who have been victims of Sexual Abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If local providers are not available, ASF shall make available the same information about national organizations. ASF shall enable reasonable communication between Detainees and these organizations as well as inform Detainees (prior to giving them access) of the extent to which ASF policy governs monitoring of their communications and when reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. ASF is required to maintain or attempt to enter into agreements with community service providers to provide Detainees with confidential emotional support services related to the Sexual Abuse while in custody, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime. ASF shall maintain copies of agreements or documentation showing unsuccessful

attempts to enter into such agreements." The Auditor reviewed an email from the facility Compliance Administrator to the Vice President of Survivor Services at STAR, which indicated that STAR is small and does not have the capabilities to fulfill an MOU agreement with ASF. The Auditor reviewed the facility Supplement to the Detainee Handbook and confirmed the detainees are provided crisis intervention resources which include the National Domestic Violence Hotline and the State of Louisiana Lafasa Sexual Assault hotline; however, a review of the facility Supplement does not confirm detainees are provided with the extent calls may be monitored or the extent to which reports of sexual abuse will be forwarded in accordance with mandatory reporting laws. During the on-site audit, the Auditor observed contact information for RAINN posted in all the housing units. An interview with the facility PA confirmed the facility is unable to assign PIN numbers to the detainees; and therefore, all calls made from the detainee phones utilizing the speed dial numbers are unmonitored and unrecorded. Detainees are not required to enter a PIN number.

Corrective Action:

No corrective action needed.

§115.54 - Third-party reporting

Outcome: Meets Standard

Notes:

ASF policy 10.1.1 states, "ASF shall post publicly GEO's third-party reporting procedures. In addition, GEO shall post on its public website its methods of receiving third-party reports of Sexual Abuse or Assault on behalf of Detainees." The Auditor reviewed the GEO website www.geogroup/prea and confirmed the website advises the public how to report allegations of sexual abuse/sexual harassment of someone in a GEO facility. In addition, contact information is provided to contact the GEO PREA Coordinator and a phone number is provided. The Auditor tested the reporting function and received an email in response within 24 hours. In addition, the Auditor tested the phone number and confirmed it was in good working order.

Corrective Action:

No corrective action needed.

§115.61 - Staff and Agency Reporting Duties

Outcome: Does Not Meet Standard

Notes:

(a)b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." ASF policy 10.1.1 states, "Employees are required to immediately report, in accordance with Agency policy, any of the following: 1) Knowledge, suspicion, or information regarding an incident of Sexual Abuse or Assault that occurred in a Facility whether or not it is a GEO Facility; 2) Retaliation against Detainees or Employees who reported such an incident or participated in an investigation about such incident; and, 3) Any Employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, Employees shall not reveal any information related to a Sexual Abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other Detainees or staff in the Facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions. Employees reporting Sexual Abuse shall be afforded the opportunity to report such information to the Chief of Security or upper-level executive privately if requested and may also utilize the

employee hotline or contact the Corporate PREA Coordinator directly to privately report these type incidents. Allegations of Sexual Abuse in which the alleged victim is under the age of 18 or considered a vulnerable adult under State or local vulnerable person's statute, ASF shall report to designated State or local services Agencies under applicable mandatory reporting laws." ASF policy 10.1.1 further states, "Contractors are required to immediately report any of the following: 1) Knowledge, suspicion, or information regarding an incident of Sexual Abuse or Assault that occurred in a Facility whether or not it is a GEO Facility; 2) Retaliation against Detainees or Employees who reported such an incident; and, 3) Any Employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, Contractors shall not reveal any information related to a Sexual Abuse report to anyone. Volunteers are required to immediately report any of the following: 1) Knowledge, suspicion, or information regarding an incident of Sexual Abuse or Assault that occurred in a Facility whether or not it is a GEO Facility; 2) Retaliation against Detainees or Employees who reported such an incident; and 3) Any Employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, Volunteers shall not reveal any information related to a Sexual Abuse report to anyone." Interviews with three random DOs confirmed they were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Interviews with three random DOs further indicated they were aware reports of sexual abuse must be kept in confidence and shared with only those who need-to-know. In addition, interviews with three random DOs confirmed they are aware of their ability to make a report outside the chain of command through the "employee hotline" which the Auditor confirmed was outside the chain of command. An interview with the facility PA confirmed the facility would not house a juvenile detainee and if the facility received an allegation of sexual abuse that involved a vulnerable adult a report would be made to the FOD and Adult Protective Services and/or the Elderly Protective Services. The Auditor reviewed one sexual abuse allegation investigation file and confirmed an allegation of sexual abuse had been made to a high-ranking staff member who failed to report the allegation.

Corrective Action:

The facility is not in compliance with subsection (b) of the standard. The Auditor reviewed one investigative file and confirmed an allegation of sexual abuse had been made to a high-ranking staff member who failed to report the allegation. To become compliant, the facility must document that all staff have received refresher training on the standard's requirement to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties should he/she become aware of such incident. In addition, if applicable, the facility must submit all sexual abuse allegation investigations that occur during the CAP period.

§115.62 - Protection Duties

Outcome: Meets Standard

Notes:

ASF policy 10.1.1 states, "When an Employee or ASF staff member has reasonable belief that a Detainee is subject to substantial risk of imminent Sexual Abuse, he or she shall take immediate action to protect the Detainee." Interviews with the facility PA, PSA Compliance Manager, and three random DOs, indicated if they become aware a detainee is at substantial risk of imminent sexual abuse the detainee would be immediately separated from the alleged abuser and an investigation would be initiated.

Corrective Action:

No corrective action needed.

§115.63 - Reporting to other Confinement Facilities

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): ASF policy 10.1.1 states, "In the event that a Detainee alleges that Sexual Abuse occurred while confined at another Facility, Staff shall document those allegations and the Facility Administrator or Chief of Security (in the absence of the Facility Administrator) where the allegation was made shall contact the Facility Administrator or designee where the abuse is alleged to have occurred and notify the ICE Field Office as soon as possible, but no later than 72 hours after receiving the notification. ASF shall maintain documentation that it has provided such notification and all actions taken regarding the incident. Copies of this documentation shall be forwarded to the PSA Compliance Manager. If ASF receives notification of alleged abuse from another facility, ASF will ensure that the allegation is investigated in accordance with PREA standards and reported to the appropriate ICE Field Office Director." The Auditor reviewed a memorandum to the file which states, "The Alexandria Staging Facility has not made notification of reporting a sexual abuse that occurred at another confinement facility in the year preceding this audit. In the event that a detainee alleges that sexual abuse occurred while confined at another facility, staff shall document those allegations and the facility administrator or chief of security (in the absence of the facility administrator where the allegation was made shall contact the facility administrator or designee where the abuse occurred and notify the ICE Field Office as soon as possible, but no later than 72 hours after receiving the notification." An interview with the facility PA indicated if the facility received notification from another facility a detainee alleged he was sexually abused while housed at ASF, the allegation would immediately be referred for an investigation and a notification would be made to the ICE FOD. The PSA Compliance Manager further indicated, if an allegation was received that a detainee was sexually abused while confined in another facility, she would notify the head of the facility within 72 hours; however, the notification is usually immediate. In addition, the facility PA indicated the notification would be made by phone and followed up with an email for documentation purposes. A review of the PREA Allegations Spreadsheet confirmed the facility has not received a sexual abuse allegation occurring at another facility, or another facility reporting an allegation that occurred at ASF during the audit period.

Corrective Action:

No corrective action needed.

§115.64 - Responder Duties

Outcome: Meets Standard

Notes:

(a)(b): ASF policy 10.1.1 states, "Upon learning of an allegation that a Detainee was Sexually Abused, or if the Employee sees abuse, the first Security Staff member to respond to the report shall: a. Separate the alleged victim and abuser; b. Immediately notify the on duty security supervisor and remain on the scene until relieved by responding personnel; c. Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; d. If the abuse occurred within a time period that still allows for the collection of physical evidence, 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 e. If the sexual abuse occurred within a time period that still allows for the collection of physical evidence, 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. f. The alleged victim and abuser should be placed (separately) in a dry cell or area, where they cannot perform the following: washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; until the forensic examination can be performed. g. A Security Staff member of the same sex shall be placed outside the cell or area for direct observation to ensure these actions are not performed. h. If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence; remain with the alleged victim and notify Security Staff. i. Apart from reporting to designated supervisors, Employees shall not reveal any information related to the incident to anyone other than to staff involved with investigating the alleged incident." The Auditor reviewed the Sexual

Abuse and Assault Prevention and Intervention (PREA) 2017 In-Service training curriculum and confirmed it includes, "Upon receipt of a report of Sexual Abuse, the first Security Staff Person to respond must: Separate the alleged victim and abuser. Immediately notify the on duty or on call supervisor and remain on the scene until relieved by responding personnel. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. Request alleged victim and Ensure abuser 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 be required to request that the alleged victim not take any actions that could destroy physical evidence; remain with the alleged victim and notify Security Staff." During interviews with three random DOs, it was confirmed all were knowledgeable and could articulate their first responder responsibilities. In addition, the Auditor interviewed two RNs, who are non-security first responders and confirmed they could articulate their responsibilities should they be the first responder on the scene of a sexual abuse.

Corrective Action:

No corrective action needed.

§115.65 - Coordinated Response

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): ASF policy 10.1.1 states, "ASF shall develop written Facility plans to coordinate the actions taken by staff first responders, Medical and Mental Health Practitioners, investigators, and Facility leadership in response to incidents of Sexual Abuse and Assault. ASF shall use a coordinated, multidisciplinary team approach to responding to Sexual Abuse and Assault. The PSA Compliance Manager shall be a required participant and the Corporate PREA Coordinator may be consulted as part of this coordinated response. If the victim of Sexual Abuse is transferred between DHS Immigration Detention Facilities, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services. If the victim of Sexual Abuse is transferred to a non-DHS Facility, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. Facilities shall utilize the "Notification of PREA Incident" form (See Attachment A of GEO Corporate Policy 5.1.2 - D)." The Auditor reviewed the facility PREA Coordinated Response Plan. A review of the plan confirmed the coordination of the actions taken by the first responders, medical and mental health practitioners, investigators, and the facility leadership in response to an incident of sexual abuse. However, a review of the PREA Coordinated Response Plan confirmed the plan does not include the requirements subsection (c) of the standard which states, "If a victim of sexual abuse is transferred between facilities covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or subsection (d) of the standard which states, "If a victim is transferred from a DHS immigration detention facility to a facility, not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise."

Corrective Action:

The facility is not in compliance with subsections (c) and (d) of the standard. The Auditor reviewed the facility PREA Coordinated Response Plan and confirmed the plan requires if the victim of Sexual Abuse is transferred between DHS Immigration Detention Facilities, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services and if the victim of Sexual Abuse is transferred to a non-DHS Facility, the sending Facility shall, as permitted by law, inform the receiving Facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. However, subsections (c) and (d) of the standard requires if a victim of sexual abuse is transferred between facilities covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c)

of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. To become complaint, the facility must revise the PREA Coordinated Response plan to include subsections (c) and (d) of the standard. Once the PREA Coordinated Response plan has been revised, the facility must submit documentation to confirm all applicable staff, to include medical and mental health, have received training on the implemented PREA Coordinated Response plan. If applicable the facility must submit all detainee sexual abuse allegation investigation files that include detainees who have been transferred from ASF during the CAP period.

§115.66 - Protection of detainees from contact with alleged abusers

Outcome: Meets Standard

Notes:

ASF policy 10.1.1 states, "Employees, Contractors and Volunteers suspected of perpetrating Sexual Abuse shall be removed from all duties requiring Detainee contact pending the outcome of an investigation. ASF shall not enter into or renew any collective bargaining agreement or other agreement that limits ASF's ability to remove alleged Employee sexual abusers from contact with any Detainee pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted." Interviews with the HRM, the facility PA, and the PSA Compliance Manager indicated that if a staff member were suspected of perpetrating sexual abuse, the staff member, would be immediately removed from detainee contact, and depending on the circumstances, a staff member could be placed on administrative leave pending the outcome of the investigation. Interviews with the HRM, the facility PA, and the PSA Compliance Manager further indicated a volunteer would be removed from detainee contact and from the facility pending the investigation. The facility does not currently enlist the services of contractors.

Corrective Action:

No corrective action needed.

§115.67 - Agency protection against retaliation

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): ASF policy 10.1.1-A states, "ASF shall employ multiple protection measures, such as housing changes or transfers for victims or abusers, removal of alleged staff or Detainee abusers from contact with victims, and emotional support services for victims or staff who fear retaliation for reporting Sexual Abuse or Assault or for cooperating with investigations." ASF policy 10.1.1 states, "ASF's PSA Compliance Manager or Mental Health personnel shall be responsible for monitoring retaliation. A Mental Health staff member or the PSA Compliance Manager shall meet weekly with the alleged victim in private to ensure that sensitive information is not exploited by staff or others and to see if any issues exist. Any issues discussed shall be noted on the "Protection from Retaliation Log (see Attachment E)", to include corrective actions taken to address the issue. For at least 90 days following a report of Sexual Abuse, ASF shall monitor the conduct and treatment of Individuals in a GEO Program or Employees who reported the Sexual Abuse to see if there are changes that may suggest possible retaliation by Detainees or staff and shall act promptly to remedy such retaliation. Items to be monitored for Detainees include disciplinary reports and housing or program changes. Items to be monitored for Employees include negative performance reviews and Employee reassignments which shall be monitored by the Human Resources Department, or an Investigator as designated by the Facility Administrator utilizing the Employee Protection from Retaliation Log. If any other individual expresses a fear of retaliation, the Staff shall take appropriate measures to protect that individual as well. Completed Logs shall be retained in the investigative file of the corresponding PREA incident." An interview with the PSA Compliance Manager indicated she is responsible for retaliation monitoring of detainee victims of sexual abuse and witnesses who participate in an investigation. An interview with the PSA Compliance Manager further indicated she would begin detainee monitoring the week after the allegation is made and would continue until the allegation is determined to be unfounded or up to 90 days and longer if needed. In addition, an interview with the PSA Compliance Manager

indicated she utilizes the GEO Protection from Retaliation Log to document retaliation monitoring. An interview with the PSA Compliance Manager confirmed she was very knowledgeable regarding monitoring disciplinary reports, housing changes, or program changes; however, she could not articulate the steps to be taken for monitoring a staff member if there was a need to do so or who was responsible for monitoring staff.

Corrective Action:

The Agency and facility are not in compliance with subsection (c) of the standard. An interview with the PSA Compliance Manager confirmed she would begin the monitoring of detainees the week after the allegation is made and would continue until the allegation is determined to be unfounded or up to 90 days and longer if needed. In an interview with the PSA Compliance Manager, it was further confirmed the PSA Compliance Manager could not articulate the steps taken for the monitoring of staff should there be a need to do so. In addition, in an interview with the PSA Compliance Manager it was confirmed there is no one responsible to monitor staff. To become compliant, the Agency and facility must implement a process to ensure all detainees who make an allegation of sexual abuse are monitored for at least 90 days regardless of it the allegation is determined to be unfounded. In addition, the Agency and facility must implement a process to ensure staff who report sexual abuse, and/or participates in the investigation, is monitored for retaliation to include reviewing negative performance reviews and staff reassignments. Once both processes have been implemented the facility must submit documentation to confirm all applicable staff, to include the PSA Compliance Manager, have received training on the standard's requirements. In addition, if applicable the facility must submit all sexual abuse allegation investigation files and the corresponding retaliation monitoring that occur during the CAP period.

§115.68 - Post-allegation protective custody

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): ASF policy 10.1.1 states, "ASF shall take care to place Detainee victims of Sexual Abuse in a supportive environment that represents the least restrictive housing option possible (e.g. protective custody), subject to the requirements of 115.43. (See Section J1). Detainee victims shall not be held for longer than five (5) days in any type of administrative restriction, except in unusual circumstances or at the request of the Detainee. A Detainee victim who is in protective custody after having been subjected to Sexual Abuse shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the Detainee as a result of the Sexual Abuse. ASF shall notify the appropriate ICE Enforcement and Removal Operations Field Office Director whenever a Detainee victim has been held in administrative restriction for 72 hours." In an interview with the facility PA, it was indicated the facility would temporarily restrict detainee victims of sexual abuse from the general population by confining them to a cell in their housing unit. An interview with the facility PA further indicated use of cell restriction to protect detainees vulnerable to sexual abuse or assault would be only until the Agency could arrange a transfer to another facility which would usually occur within hours of placement. In an interview with the facility PA, it was further indicated the FOD would immediately be notified to arrange transport and if the facility determines the detainee victim could continue to house at ASF a reassessment would be conducted prior to placing the detainee back into general population.

Corrective Action:

No corrective action needed.

§115.71 - Criminal and administrative investigations

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(e)(f): ASF policy 10.1.1-A states, "Criminal and Administrative Agency Investigations- a. An administrative or criminal investigation shall be completed for all allegations of Sexual Abuse. b. The Facility Administrator and contracting agencies shall be notified prior to investigating all allegations of Sexual Abuse. c.

Specific procedures not listed in this policy which are required by contractual obligations shall be followed. Where any requirements of the DHS PREA Standards may conflict with PBNDS 2011, the DHS PREA Standards shall supersede. (i) Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; (ii) Interviewing alleged victims, suspected perpetrators, and witnesses; (iii) Reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; (iv) Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph; (v) An effort to determine whether actions or failures to act at the facility contributed to the abuse; and (vi) Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and (vii) Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. When ASF conducts its own investigations into allegations of Sexual Abuse, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. ASF shall use investigators who have received specialized training in Sexual Abuse investigations. The specialized training shall include techniques for interviewing Sexual Abuse victims, proper use of Miranda and Garrity warnings, Sexual Abuse evidence collection and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. e. When outside agencies investigate Sexual Abuse, ASF shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Facilities shall request copies of completed investigative reports. Upon receipt, the investigative report will be forwarded to the Corporate PREA Director for review and closure." ASF policy 10.1.1-A further states, "An investigative report shall be written for all investigations of allegations of Sexual Abuse. ASF shall utilize the investigative report template (See attachment A) for all PREA investigations unless another format is required by the contracting agency. b. Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of Sexual Abuse involving the suspected perpetrator. c. administrative investigations (1) shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) shall be documented in a written report format that includes at a minimum, a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings." An interview with the PSA Compliance Manager/Investigator, indicated the facility will complete an administrative investigation on all allegations as soon as RPSO and the ICE OPR indicates an investigation can begin. An interview with the PSA Compliance Manager/Investigator further indicated she would remain in constant contact with the RPSO, and a sexual abuse allegation investigation would continue regardless of if the victim or the abuser (staff or detainee) is no longer at the facility. The Auditor reviewed and confirmed the facility Investigator is qualified and has completed specialized training in sexual abuse and effective cross-agency coordination and the facility general PREA training as required by §115.31. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the sexual abuse allegation investigation included the elements required by the standard.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (e) of the standard. The Auditor reviewed ASF policy 10.1.1-A and confirmed it includes all elements required by subsection (c) of the standard. However, the Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not contain include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the sexual abuse allegation investigation included the elements required by the standard. To become compliant the facility must submit documentation to confirm the facility Investigator has received training on the standard's requirement to ensure all allegations of sexual abuse are investigated in accordance with subsections

(a), (b), (c), (e), and (f) of the standard. In addition, if applicable, the facility must submit all sexual abuse allegation investigation files that occur during the CAP period.

§115.72 - Evidentiary standard for administrative investigations

Outcome: Does Not Meet Standard

Notes:

Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse." ASF policy 10.1.1-A states, "Facilities shall impose no standard higher than a preponderance of the evidence in determining whether allegations of Sexual Abuse are Substantiated." An interview with the PSA Compliance Manager/Investigator confirmed the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the facility Investigator imposed no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse.

Corrective Action:

The facility is not in compliance with standard 115.72. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the investigation centered on a staff member's failure to report the allegation reported by a detainee and did not contain include any documentation to confirm the allegation of sexual abuse had been investigated; and therefore, the Auditor could not confirm the facility Investigator imposed no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse. To become compliant the facility must submit documentation to confirm the facility Investigator has received training on the standard's requirement to impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse. In addition, if applicable, the facility must submit all sexual abuse allegation investigation files that occur during the CAP period.

§115.73 - Reporting to detainees

Outcome: Meets Standard

Notes:

An interview with the PSA Compliance Manager, indicated detainee victims of sexual abuse would be notified of the result of the investigation. The Auditor reviewed one investigative file and could not confirm the facility provided the detainee notification of the results of the investigation. The Auditor submitted a Notification of PREA Investigation Results to Detainee to the ERAU Team Lead. The Auditor reviewed the Notification of PREA Investigation Results to Detainee which indicated "ERO New Orleans was not notified of the incident until after the non-citizen had been removed. Removal was on March 4, 2022. Since the detainee was removed before ERO even received the allegation, we were not able to send him the decision letter. He is a citizen of Honduras and left no forwarding address."

Corrective Action:

No corrective action needed.

§115.76 - Disciplinary sanctions for staff

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): ASF policy 10.1.1-A states, "Staff shall be subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiated allegations of Sexual Abuse or for violating agency or facility Sexual Abuse policies. The Agency shall review and approve facility policies and procedures regarding disciplinary or adverse actions for staff and shall ensure that the facility policy and

procedures specify disciplinary or adverse actions for staff, up to and including removal from their position and from the Federal service for staff, when there is a substantiated allegation of Sexual Abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Removal from their position and from the Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in Sexual Abuse, as defined under the definition of Sexual Abuse of a Detainee by an Employee, Contractor, or Volunteer. ASF shall report all removals or resignations in lieu of removal for violations of Agency or facility Sexual Abuse policies to appropriate law enforcement agencies unless the activity was clearly not criminal. ASF 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." Interviews with three random DOs indicated they were all aware they would be terminated if they violated the facility sexual abuse policies. In an interview with the facility PA, it was indicated staff are subject to disciplinary action up to and including termination for violations of the Agency and facility policies regarding sexual abuse. An interview with the facility PA it was further indicated a report would be made to local law enforcement and if determined to be substantiated a report would be made to any licensing bodies. The Auditor reviewed one investigative file and confirmed a staff member had failed to report an allegation of sexual abuse and the facility had disciplined the staff member for violating the facility SAAPI policy and failing to report an allegation. In an interview with the DFOD it was confirmed ASF policy 10.1.1 had been submitted and approved by the Agency.

Corrective Action:

No corrective action needed.

§115.77 - Corrective action for contractors and volunteers

Outcome: Meets Standard

Notes:

(a)(b)(c): ASF policy 10.1.1-A states, "Any contractor or volunteer who has engaged in Sexual Abuse shall be prohibited from contact with Detainees. ASF shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated Sexual Abuse by a Contractor or Volunteer. Such incidents shall also be reported to law enforcement agencies unless the activity was clearly not criminal. Contractors and Volunteers suspected of perpetrating Sexual Abuse shall be removed from all duties requiring Detainee contact pending the outcome of an investigation. ASF shall take appropriate remedial measures and shall consider whether to prohibit further contact with Detainees by Contractors or Volunteers who have not engaged in Sexual Abuse but have violated other provisions within these standards." Interviews with the HRM and the PSA Compliance Manager indicated any volunteers suspected of perpetrating sexual abuse would be removed from all duties involving detainee contact and law enforcement would be notified. Interviews with the HRM and the PSA Compliance Manager further indicated the incident would be reported to the contractor's employer and all licensing bodies. An interview with the PSA Compliance Manager indicated the facility has not had an allegation involving a volunteer. The Auditor reviewed the PREA Allegation Spreadsheet and confirmed there were no allegations of sexual abuse which involved a volunteer. The facility does not use the services of contractors.

Corrective Action:

No corrective action needed.

§115.78 - Disciplinary sanctions for detainees

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): ASF policy 10.1.1-A states, "ASF shall subject a Detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the Detainee engaged in Sexual Abuse. At all steps in the disciplinary process any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the Detainee to conform with rules and regulations in the future. ASF shall have a Detainee disciplinary system with progressive levels of reviews, appeals, procedures,

and documentation procedure. The disciplinary process shall consider whether a Detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. ASF shall not discipline a Detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of Sexual Abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The PSA Compliance Manager shall receive copies of all disciplinary reports regarding Sexual Activity and Sexual Abuse for monitoring purposes." Interviews with the facility Disciplinary Officer, the PSA Compliance Manager, and the facility PA indicated although ASF policy 10.1.1-A and a review of the facility Supplement to the National Detainee Handbook confirms a hearing would be held and includes sanctions that can be imposed, the facility does not have the ability to discipline a detainee.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. Interviews with the facility Disciplinary Officer, the PSA Compliance Manager and the facility PA indicated although ASF policy 10.1.1-A and a review of the facility Supplement to the National Detainee Handbook confirms a hearing would be held and includes sanctions that can be imposed, the facility does not have the ability to discipline a detainee. To become compliant, the facility must establish a practice to ensure the facility subjects detainees to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse. Once implemented the facility must submit documentation which confirms all applicable staff, to include the Disciplinary Officer and PSA Compliance Manager, have been trained on the implemented practice. In addition, if applicable, the facility must submit any detainee-on-detainee sexual abuse allegation investigations determined to be substantiated and the corresponding disciplinary report that occur during the CAP period.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "If during the intake assessment, persons tasked with screening determine that a Detainee is at risk for either sexual victimization or abusiveness, or if the Detainee has experienced prior victimization or perpetrated sexual abuse, the Detainee shall be referred to a Qualified Medical and/or Mental Health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the Detainee shall receive a health evaluation no later than two (2) 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. Information related to sexual victimization or abusiveness in an institutional setting is limited only to Medical and Mental Health Practitioners and other Employees as necessary to inform treatment plans, security and management decisions or otherwise required by Federal, State, or local law." The Auditor interviewed two Processing Officers who indicated detainees are asked the questions on the initial risk assessment and if a detainee discloses he has experienced sexual abuse or has perpetrated sexual abuse, they will notify the Intake supervisor who will come to the desk and sign the assessment. However, interviews with two Processing Officers confirmed the two Processing Officers could not articulate the requirement to refer detainees who disclose prior sexual abuse or have perpetrated sexual abuse to medical or mental health for a medical or mental health follow-up. The Auditor reviewed 18 detainee files and confirmed 1 detainee had reported previous sexual abuse and had previously been convicted of sexual assault of a child and the Intake Supervisor had initialed the initial risk assessment form; however, neither the Processing Officer or the Intake supervisor who initialed the initial risk assessment form referred the detainee to medical or mental health for a follow-up. Interviews with two RNs indicated if a detainee disclosed sexual abuse or perpetrated sexual abuse a referral would be forwarded to mental health staff for an evaluation; however, a referral would only be made if the sexual abuse occurred within the six months prior to Intake processing. Interviews with two RNs further indicated if a referral was received from Intake Processing a follow-up medical assessment would be conducted immediately but no later than two days following the referral. An

interview with an LCSW indicated if a referral were received a follow-up mental health assessment would be conducted immediately but no later than 72 hours following the referral.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The Auditor interviewed two Processing Officers who indicated detainees are asked the questions on the initial risk assessment and if a detainee discloses he has experienced sexual abuse or has perpetrated sexual abuse, they will notify the Intake supervisor who will come to the desk and sign the assessment. However, interviews with two Processing Officers confirmed the two Processing Officers could not articulate the requirement to refer detainees who disclose prior sexual abuse or have perpetrated sexual abuse to medical or mental health for a medical or mental health follow-up. Interviews with two RNs indicated if a detainee disclosed sexual abuse or perpetrated sexual abuse a referral would be forwarded to mental health staff for an evaluation; however, a referral would only be made if the sexual abuse occurred within the six months prior to Intake processing. The Auditor reviewed 18 detainee files and confirmed 1 detainee had reported previous sexual abuse and had previously been convicted of sexual assault of a child and the Intake Supervisor had initialed the initial risk assessment form; however, neither the Processing Officer or the Intake supervisor who initialed the initial risk assessment form referred the detainee to medical or mental health for a follow-up. To become compliant, the facility must implement a process to ensure if the initial risk assessment indicates a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff will, as appropriate, ensure the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. Once implemented, the facility must submit documentation that confirms all applicable staff have been trained on the implemented process. In addition, the facility must provide the Auditor, if applicable, detainee files which include detainees who have previously experienced sexual abuse or who have perpetrated sexual abuse that are received during the CAP period to confirm detainees who disclose prior sexual abuse or have perpetrated sexual abuse are referred to medical or mental health for a medical or mental health follow-up.

§115.82 - Access to emergency medical and mental health services

Outcome: Meets Standard

Notes:

(a)(b): IHSC policy 03-01 states, "Provide emergency medical and mental health services to detainees who are victims of sexual abuse. Services include Initial evaluation; ongoing mental health care; examination; and referrals. Emergency medical treatment. Crisis intervention services including emergency contraception, sexually transmitted infections testing, and prophylaxis. Pregnancy tests for females. Ensure victims of sexual abuse have timely, unimpeded access to services. Mental health assessments must be completed within 72 hours of the referral. Medical referrals must be completed within two working days. Provide treatment services to the victim without financial cost, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Arrange transportation for emergency care or other off-site services in a matter that considers the special needs of victimized detainees." ASF policy 10.1.1 states, "Victims of Sexual Abuse in custody shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by Medical and Mental Health Practitioners. This access includes offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." Interviews with two IHSC RNs indicated should a detainee be a victim of a sexual abuse the medical staff would triage the detainee to address any emergency medical needs and the detainee would be transported to the St. Francis Cabrini Hospital SANE unit, if needed. Interviews with two IHSC RNs further indicated the hospital would provide emergency medical treatment, including emergency contraception and sexually transmitted infections prophylaxis. In addition, interviews with two IHSC RNs indicated IHSC medical staff would continue follow-up care once the detainee is returned to the facility, services are provided at no financial cost to the detainee, would be provided regardless of the detainee naming their abuser, and in accordance with professionally accepted standards of care. The Auditor reviewed an email from the facility

Compliance Administrator to the Vice President of Survivor Services at STAR, which indicated STAR is small and does not have the capabilities to fulfill an MOU agreement with ASF. However, the email confirmed that any detainee survivor who presents at St. Francis Cabrini Hospital would be offered crisis intervention services. During the on-site audit, the Auditor contacted St. Francis Cabrini Hospital and confirmed the hospital has a SANE Unit; however, the RN SANE Coordinator was not available to speak with the Auditor during the on-site audit to confirm what emergency services they could offer a detainee victim of sexual abuse. The Auditor reviewed a memorandum to the file which states, "The Alexandra Staging Facility has not demonstrated emergency medical/mental health services provided to a detainee victim in a timely manner without financial cost during the reporting period." The Auditor reviewed one sexual abuse allegation investigation file and confirmed the detainee had been immediately referred to mental health; however, an interview with the LCSW and review of the detainee's mental health file confirmed mental health staff were not notified of the detainee's allegation of sexual abuse; and therefore, sexual abuse protocols to include crisis intervention were not offered. In addition, a review of one sexual abuse allegation file confirmed the detainee was not offered timely unimpeded access to emergency medical treatment. However, based on the facility's policy, staff interviews, and the Auditor's confirmation that the facility lacked knowledge surrounding the allegation of sexual abuse, the Auditor finds the facility in substantial compliance with subsection (a) of the standard.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): IHSC policy 03-01 states, "IHSC provides access to emergency medical and mental health services and ongoing care for detainees who are victims of sexual abuse. Initial Evaluation: After any allegation of sexual assault or abuse, a health care provider sees the alleged victim for a medical evaluation. The health care provider evaluates the detainee and, in collaboration with the clinical director (CD) and health services (HSA), refers all suspected assault and abuse to the BHP, physician, or qualified health care provider for a mental health evaluation. The appropriate medical or mental health staff conduct medical and/or mental health interventions to meet the detainee's needs. If no medical or mental health staff are available to evaluate and assess, staff coordinate the detainee's transfer to an outside facility for appropriate level of care and assessment. Care may include a forensic medical evaluation involving the collection of evidence, using a kit approved by the proper authority, if necessary. Timely, unimpeded access to treatment and services. This includes Emergency medical treatment. IHSC qualified health care staff offers crisis intervention services, including emergency contraception, sexually transmitted infections, and other infectious diseases (e.g., HIV, hepatitis B and C) testing, and prophylactic treatment to all victims in accordance with NCCHC 2018 standards. Pregnancy tests, for female detainees who experienced vaginal penetration by a male abuser while incarcerated. Victims receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services." ASF policy 10.1.1 states, "ASF shall offer medical and mental health evaluations (and treatment where appropriate) to all victims of Sexual Abuse while in immigration detention. The evaluation and treatment should include follow-up services, treatment plans, and (when necessary) referrals for continued care following their transfer to, or placement in, other Facilities, or their release from custody. These services shall be provided in a manner that is consistent with the level of care the individual would receive in the community. Victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of Sexual Abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services. Victims shall also be offered tests for sexually transmitted infections as medically appropriate. All services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." Interviews with two IHSC RNs indicated should a detainee be a victim of a sexual abuse, the medical staff would triage the detainee to address any emergency medical needs and the detainee would be transported to the St. Francis Cabrini Hospital SANE unit, if needed. The hospital would provide emergency

medical treatment, including emergency contraception and sexually transmitted infections prophylaxis. The IHSC medical staff would continue follow-up care once the detainee is returned to the facility. Services provided are consistent with community level care, at no financial cost to the detainee and would be provided regardless of the detainee naming their abuser and in accordance with professionally accepted standards of care. The Auditor reviewed an email from the facility Compliance Administrator to the Vice President of Survivor Services at STAR, which indicated that STAR is small and does not have the capabilities to fulfill an MOU agreement with ASF. However, the email confirmed that any detainee survivor who presents at St. Francis Cabrini Hospital has the right to an advocate, and one would be dispatched once the forensic nurse requests one. Additionally, STAR provides advocacy (case management, crisis intervention, safety planning, accompaniments) to all survivors that reside in Avoyelles, Catahoula, Concordia, Grant, La Salle, Rapides, Vernon, and Winn Parish. The Auditor contacted St. Francis Cabrini Hospital and confirmed St. Francis Cabrini Hospital does have a SANE Unit, however, the RN SANE Coordinator was unable to speak with the Auditor to confirm the services offered to a detainee victim.

(g): IHSC policy 03-01 states, "Behavioral health provider: Completes mental health assessments within 72 hours of referral. Conducts mental health evaluation of all known detainee-on- detainee sexual abusers. Documents the evaluation and ensures it is placed in the electronic health record." ASF policy 10.1.1 states, "ASF shall attempt to conduct a mental health evaluation on all known Detainee-on-Detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by Mental Health Practitioners. All refusals for mental health services shall be documented." The Auditor reviewed a memorandum to the file which states, "The Alexandria Staging Facility has not demonstrated an attempt made to conduct a mental health evaluation of a detainee-on-detainee abuser within 60 days during this reporting period. An interview with the LCSW indicated, if the detainee abuser is willing to participate, a mental health evaluation would be completed and offered treatment, at no financial cost to the detainee, however the LCSW indicated that a known detainee abuser would not be at the facility long enough to benefit from the services that can be provided.

Corrective Action:

No corrective action needed.

§115.86 - Sexual abuse incident reviews

Outcome: Meets Standard

Notes:

(a)(b)(c): ASF policy 10.1.1 states, "Designated Staff shall conduct a Sexual Abuse incident review at the conclusion of every Sexual Abuse investigation in which the allegation has been determined substantiated or unsubstantiated. Such review shall occur within 30 days of the conclusion of the investigation. The review team shall consist of upper-level management officials, the local PSA Manager, Medical and Mental Health Practitioners. The Corporate PREA Coordinator may attend via telephone or in person. A "PREA After Action Review Report" (see Attachment F) of the team's findings shall be completed and submitted to the local PSA Manager and Corporate PREA Coordinator no later than 10 working days after the review. ASF shall implement the recommendations for improvement or document its reasons for not doing so. Annually, ASF shall conduct a review of all Sexual Abuse investigations and resulting incident reviews to assess and improve Sexual Abuse intervention, prevention, and response efforts. If there have not been any reports of Sexual Abuse during the annual reporting period, then ASF shall prepare a negative report. ASF shall document the review utilizing the "DHS Annual Review of Sexual Abuse Incidents" form. (See Attachment G of Corporate Policy 5.1.2 - D). The results and findings of the annual review shall be provided to the Facility Administrator, Field Office Director, or his/her designee, GEO Corporate PREA Coordinator, and the agency PSA Coordinator upon completion." In an interview with the PSA Compliance Manager, it was indicated the review team consists of upper-level management officials and allows for input from the security line supervisors, Investigator, and medical and mental health practitioners. The PSA Compliance Manager further indicated the facility would do an incident review utilizing a Sexual Abuse or Assault Incident Review form on all investigations, including those

determined to be unfounded, within 30 days of the conclusion of the investigation. The Auditor reviewed the Sexual Abuse or Assault Incident Review form and confirmed the form included all elements required by subsection (b) of the standard. The Auditor reviewed one investigative file and confirmed the facility had completed a sexual abuse incident review within 30 days of the conclusion of the investigation. In addition, the Auditor reviewed the ASF 2022 Annual Review of Sexual Abuse Investigations and Corrective Action Plan and confirmed the report had been signed by the FA and submitted to the FOD, GEO Corporate PREA Coordinator and ero.sexualassault@ice.dhs.gov.

Corrective Action:

No corrective action needed.

§115.87 - Data collection

Outcome: Meets Standard

Notes:

(a): ASF policy 10.1.1 states, "ASF shall collect and retain data related to Sexual Abuse as directed by the Corporate PREA Coordinator. ASF shall maintain in a secure area all case records associated with claims of Sexual Abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary, and/or counseling in accordance with the PREA standards and applicable agency policies and established schedules." An interview with the PSA Compliance Manager/Investigator indicated that the facility maintains all case records associated with an allegation of sexual abuse in her office, which is located in a nearby facility; and therefore, the Auditor did not have an opportunity during the on-site audit to observe the area.

Corrective Action:

No corrective action needed.

§115.201 - Scope of Audit

Outcome: Meets Standard

Notes:

(d)(e)(i)(j): During all stages of the audit, including the on-site audit, the Auditor was able to review available memos and other documentation required to make an assessment on PREA Compliance. Interviews with detainees were conducted privately on-site and remain confidential. The Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. No detainees, outside entity, or staff correspondence was received prior to the on-site audit or during the post audit review.

Corrective Action:

No corrective action needed.

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.

Robin Bruck 12/19/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 12/19/2023

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 12/19/2023

Assistant Program Manager's Signature & Date