PREA Audit: Subpart B
DHS Holding Facilities
Corrective Action Plan Final Determination

Homeland Security

AUDITOR INFORMATION			
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	ERO El Paso Field Office		
ICE Field Office Director:	Mary De Anda-Ybarra		
PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	11541 Montana Avenue, Suite E, El Paso, Texas 79936		
Mailing address: *(if different from above)*	Same as above		
INFORMATION ABOUT FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	ICE El Paso Hold Room		
Physical address:	11541 Montana Avenue, Suite E, El Paso, Texas 79936		
Mailing address: *(if different from above)*	Same as above		
Telephone number:	915-856-5504		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Field Office Director (FOD)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	915-856-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer (SDDO)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	915-269-(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 ICE El Paso Hold Room met 18 standards, had 0 standards that exceeded, had 1 standard that was non-applicable, and had 11 non-compliant standards. As a result of the facility being out of compliance with 11 standards, the facility entered into a 180-day corrective action period which began on June 5, 2023, and ended on December 2, 2023. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Initially Not Met: 11

§115.113 Detainee supervision and monitoring
§115.115 Limits to cross-gender viewing and searches
§115.116 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.118 Upgrades to facilities and technologies
§115.121 Evidence protocol and forensic medical examinations
§115.131 Employee, contractor, and volunteer training
§115.132 Notification to detainees of the agency's zero-tolerance policy
§115.141 Assessment for risk of victimization and abusiveness
§115.151 Detainee reporting
§115.165 Coordinated response
§115.182 Access to emergency medical services

Staging Facility Risk Rating:

§115.193 Audits of standards – Not Low Risk

The facility submitted documentation, through the Agency, for the CAP from July 17, 2023, through December 2, 2023. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on December 2, 2023. In a review of the submitted documentation, to demonstrate compliance with the deficient standards, the Auditor determined compliance with all 11 of the standards.

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.

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

(a)(b)(c): ICE Directive 11087.1 states, "The FOD shall ensure that each holding facility maintains sufficient supervision of detainees, including through appropriate staffing levels and where applicable, video monitoring, to protect detainees against sexual abuse and assault. In so doing the FOD shall take into consideration a) The physical layout of each holding facility; b) The composition of the detainee population; c) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; d) The findings and recommendations of the sexual abuse review reports; e) Any other relevant factors, including the length of time detainees spend in custody at the holding facility. The FOD shall ensure that detainees placed into the holding facilities are subject to direct supervision, (b) (7)(E) [redacted] n addition, ICE Directive 11087.1 further states, "The FOD shall at least annually review the application of this policy at each holding facility within his or her AOR to ensure ongoing compliance." According to the PAQ there are 31 staff employed at IEPHR, which includes 24 male DDOs and 7 female DDOs; however, during the on-site audit, the facility reported a total of 30 staff positions, which includes an AFOD, 4 SDDOs, and 25 DDOs (22 male and 3 female), to cover 3 shifts, 0600-1400, 1400-2200, and 2200-0600. An interview with the PSA Compliance Manager indicated, during detainee processing, there are always two DDOs present to monitor the detainees. In addition, the PSA Compliance Manager indicated when determining adequate staffing levels and the need for video monitoring, the Agency will consider the physical layout of the holding facility, the composition of the detainee population, the length of time detainees spend in the Agency custody, and any other relevant factors. In addition, the PSA Compliance Manager indicated the Agency would consider substantiated or unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other factors; however, the facility has not had a reported sexual abuse allegation. While on-site the Auditor observed three holding cells. Each holding cell had large observation windows that allowed for DDOs to have the ability to see the entirety of the hold rooms from their workstations. (b) (7)(E) [redacted] There are a total of (b) (7)(E) which are (b) (7)(E) [redacted] (b) (7)(E) [redacted] IEPHR provided the Auditor the facility Hold Facility Self-Assessment Tool (HFSAT), dated 12/13/2017; however, this process is required to be completed annually. The document's purpose states, "It is used to determine if the facility maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse"; however, a review of the HFSAT confirms it does not include documentation to confirm the Agency took into consideration the elements required by subsection (c) of the standard when determining adequate staffing or the need for video monitoring or the supervision guidelines were reviewed to determine their application at IEPHR for the years 2022 or 2023. In addition, a review of the HFSAT confirms it states, "according to Section 4.1 of the Holding Facilities Directive, personnel will perform physical hold room checks at least every 15 minutes. These checks will be logged, including the time of each check and any important observations on the Holding Facility Inspection Log"; however, interviews with four DDOs confirmed due to the open construction of the holding facility, which allows for maximum viewing of all holding cells at all times, physical hold room checks are not conducted at IEPHR.

Does Not Meet (b)(c): IEPHR is not in compliance with subsections (b) and (c) of the standard. An interview with the PSA Compliance Manager indicated when determining adequate staffing levels and the need for video monitoring, the Agency would consider the physical layout of the holding facility, the composition of the detainee population, substantiated or unsubstantiated incidents of sexual abuse, the length of time detainees spend in the Agency custody, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors; however, a review of the HFSAT confirms it does not include documentation to confirm the Agency took into consideration the elements required by subsection (c) of the standard when determining adequate staffing or the need for video monitoring. In addition, a review of the HFSAT could not confirm that the Agency developed comprehensive supervision guidelines or that the supervision guidelines were reviewed to determine their application at IEPHR for the years 2022 or 2023. To become compliant the facility must provide documentation that the Agency took into consideration the physical layout of each 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 agency custody when determining adequate supervision or the need for video monitoring. In addition, the facility must provide the Auditor with documentation to confirm that the supervision guidelines were reviewed during the last year as required by subsection (b) of the standard.

Corrective Action Taken (b)(c): The facility submitted an updated HFSAT. The Auditor reviewed the updated HFSAT and confirmed when determining adequate staffing and the need for video monitoring the Agency considered the physical layout of the facility, the composition of the detainee population, the prevalence, finding and recommendations of incidents of sexual

abuse, and other factors including the length of time the detainees are spending in the IEPHR. In addition, a review of the HFSAT confirmed the Agency reviewed and updated the comprehensive supervision guidelines. Upon review of all submitted documentation, the Auditor now finds the facility in compliance with subsections (b) and (c) of the standard.

§115.115 - Limits to cross-gender viewing and searches
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(b)(c)(e)(f): ICE Directive 11087.1 states, "Strip and Visual Body Cavity Searches - The FOD shall ensure that when pat down searches indicate the need for a more thorough search, an extended search (i.e., strip search) is conducted in accordance with ICE policies and procedures, including that: a) All strip searches and visual body cavity searches are documented; b) Cross-gender strip searches or cross-gender visual body cavity searches are not conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners; and c) Visual body cavity searches of minors are conducted by a medical practitioner and not by law enforcement personnel." ICE Directive 11087.1 further states, "The FOD shall ensure that ERO personnel do not search or physically examine a detainee for the sole purpose of determining the detainee's gender. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records (if available), or, if necessary, learning that information as part of a broader medical examination conducted in private, by a medical practitioner." In addition, ICE Directive 11087.1 states, "The FOD shall ensure that all pat-down searches are conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and ICE policy, including consideration of officer safety. Where operationally feasible, an officer of the same gender as the detainee will perform the pat down search." Interviews with the PSA Compliance Manager and four DDOs indicated that strip searches, cross-gender strip searches, and cross-gender visual body cavity searches are not conducted at the facility. If there were exigent circumstances, which required a strip search or a visual body cavity search, the detainee would be taken to El Paso Processing Center for medical personnel to perform the search. Interviews with four DDOs further confirmed as the strip/body cavity search was being conducted at El Paso Processing Center they would be responsible for documenting the search. The Auditor reviewed the facility Cross-Gender, Transgender, and Intersex Searches training curriculum and confirmed it includes the requirement that all searches shall be performed in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. In addition, the training curriculum includes the requirements at no time shall any search be conducted solely for the purpose of determining a detainee's genital characteristics or gender and if the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination at intake or other processing procedures conducted in private, by a medical practitioner. The Auditor was provided a list of facility participants who attended a Teams meeting. The documentation indicated the date and time each staff member joined the Teams meeting; however, no documentation was provided to indicate the purpose of the Teams meeting or what the meeting entailed; and therefore, the Auditor could not confirm staff have received the required training. Interviews with four DDO's indicated cross-gender pat-down searches are not conducted at IEPHR as female staff from Homeland Security Investigations (HSI) would be available to conduct the search if no IEPHR female staff were on duty should a pat-down search be necessary; however, should the need occur, they would be documented. Interviews with four DDOs further confirmed they were aware you could not search or physically examine a detainee for the sole purpose of determining the detainee's gender; however, each DDO struggled with how to conduct a pat-down search of a transgender/intersex detainee or who should conduct the search. In addition, interviews with four DDOs confirmed they could not articulate that the search must be done in a professional and respectful manner. As detainees are pat-down searched prior to being processed at IEPHR, there were no pat-down searches or available video of pat-down searches for the Auditor to observe.

Does Not Meet (f): IEPHR is not in compliance with subsection (f) of the standard. The Auditor was provided a list of facility participants who attended a Teams meeting. The documentation indicated the date and time each staff member joined the Teams meeting; however, no documentation was provided to indicate the purpose of the Teams meeting or what the meeting entailed; therefore, the Auditor could not confirm staff have received the required training. Interviews with four DDO's confirmed each DDO struggled with how to conduct a pat-down search of a transgender/intersex detainee or who should conduct the search. In addition, interviews with four DDOs confirmed they could not articulate the search must be done in a professional and respectful manner. To become compliant, the facility must provide the Auditor with documentation that confirms all IEPHR SDDOs and DDOs have received training in the proper procedures for conducting pat-down searches, including how to conduct a pat-down search of a transgender/intersex detainee, who should conduct the search of a transgender/intersex detainees, and the search must be done in a professional and respectful manner. (d): ICE Directive 11087.1 states, "The FOD shall ensure that detainees are permitted to shower (where showers are available), perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine hold room checks, or is otherwise appropriate in connection with a medical exam or monitored bowel movement under medical supervision." ICE Directive 11087.1 further states, "The FOD will also ensure that ERO personnel of the opposite gender announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." During the on-site audit, the Auditor observed that each hold room had large observation windows, which allowed the DDOs to see the entirety of the rooms. A toilet area was observed in each hold room and was blocked by a wall that had sufficient height and length to prevent viewing by staff of the opposite

gender when the detainees are utilizing the toilet. In addition, the Auditor observed camera location and the monitor view and confirmed detainees are able to perform bodily functions without being viewed by opposite-gender staff who monitor the camera system. The hold rooms did not have showers or changing areas.

Corrective Action Taken (f): The facility submitted the Detainee Searches curriculum. The Auditor reviewed the Detainee Searches curriculum and confirmed the training curriculum includes the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and includes that all pat-down searches shall be conducted in a professional and respectful manner. The facility submitted the ICE Cross-Gender, Transgender, and Intersex Search curriculum. The Auditor reviewed the ICE Cross-Gender, Transgender and Intersex Search curriculum and confirmed the curriculum includes searches of transgender or intersex detainees shall be conducted in the least intrusive manner consistent with security needs and agency policy, including consideration of officer safety and officers conducting the search must be the same gender, gender identity or declared gender as the detainee being searched. The facility submitted eight certificates of completion which confirmed IEPHR staff have completed the required training. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (f) of the standard.

§115.116 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): ICE Directive 11087.1 states, "The FOD shall take appropriate steps to ensure that the detainees with disabilities have an equal opportunity to participate in and benefit from the processes and procedures in connection with placement in an ERO holding facility, consistent with established statutory, regulator, DHS and ICE policy requirements." ICE Directive 11087.1 further states, "The FOD shall take reasonable steps to ensure meaningful access to detainees who are limited English proficient, consistent with established regulatory and DHS and ICE policy requirements." ICE Directive 11062.2 states, "In matters relating to allegations of sexual abuse or assault, ensure the provision of in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretations, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS Policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse or assault, and detainees who have a significant relationship with the alleged abuser, is not appropriate in matters relating to allegations of sexual abuse or assault." Interviews with the PSA Compliance Manager and four random DDOs indicated that IEPHR utilizes the services of ERO Language Services, provided by Lionbridge, to communicate with those detainees who are limited English proficient (LEP). Interviews with the PSA Compliance Manager and four DDOs further indicated they were aware of the availability and location of the instructions for utilizing the line and advised the Lionbridge flyer with instructions for accessing the language line was located in the processing area which was confirmed by the Auditor. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice in English and Spanish in the intake processing area and in each hold room. In addition, the Auditor observed the ICE National Detainee Handbook in the processing area, in both English and Spanish. In interviews with four DDOs, it was indicated should a detainee speak a language other than English or Spanish, they would access the facility computer to print the ICE National Detainee Handbook in the required language. The Auditor reviewed the facility computer and confirmed the facility has access to the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor observed the facility did not have the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet onsite. During the onsite audit IEPHR obtained the pamphlet in the 15 most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the written information included in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. Interviews with four DDOs confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or low vision, had limited reading skills, or had an intellect, psychiatric, or speech disability. During the on-site audit, the Auditor confirmed the facility does not have access to written material, in-person, telephonic or video interpretive services that enable effective and accurate communication with detainees who may suffer from these types of disabilities. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or otherwise disabled the IEPHR would be notified prior to the detainee being transported to the holding room for processing and the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. During the on-site audit, the facility did not receive a detainee for processing; however, the Auditor reviewed a video recording of two detainees being processed at the facility the day prior to the on-site audit. A review of the video confirmed both detainees were at the facility for less than 30 minutes with one detainee being placed in a holding cell for less than five minutes and one detainee not being placed in a holding cell. Neither detainee had been given any written documentation during the process. In interviews with four DDOs it was indicated if a sexual abuse were to occur in the hold room, staff would not utilize another detainee (minor or adult), a detainee who witnessed the alleged abuse, the abuser or those who have a significant relationship with the alleged abuser, for interpretation services on sexual abuse matters and if the alleged victim expressed a preference for another detainee to provide the service, staff would notify the supervisor to ensure that interpretation is appropriate and consistent with DHS policy.

Does Not Meet (a)(b): IEPHR is not in compliance with subsections (a) and (b) of the standard. During the onsite audit, the Auditor observed the DHS-prescribed sexual assault awareness notice in the intake processing area and in each hold room in English and Spanish only. In addition, during the onsite audit, the Auditor confirmed the facility did not have the DHS-prescribed SAA Information pamphlet readily available. IEPHR had obtained the pamphlet in the 15 most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the PREA information contained in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. During the onsite audit, the Auditor further observed the ICE National Detainee Handbook in the processing area, in both English and Spanish. In interviews with four DDOs it was indicated should a detainee speak a language other than English or Spanish they would access the facility computer to print the ICE National Detainee Handbook in the required language. The Auditor reviewed the facility computer and confirmed the facility has access to the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video recording of two LEP detainees being processed at the facility and confirmed neither detainee had been given any written material. Interviews with four DDOs, confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or had low vision, had limited reading skills, or an intellectual, psychiatric, or speech disability. During the onsite audit, the Auditor confirmed the facility does not have access to written material, in-person, telephonic, or video interpretive services that would enable effective and accurate communication with detainees who may suffer from these types of disabilities. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or otherwise disabled the IEPHR would be notified prior to the detainee being transported to the holding room for processing and the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. To become compliant, the facility must institute a practice of providing the detainee who does not speak English or Spanish the PREA information in a manner they could understand. In addition, the facility must institute a practice of providing a detainee who is blind or have low vision, deaf or hard of hearing, or those who have intellectual, psychiatric, or speech disabilities access to the PREA information to include access to written material, in-person, telephonic, or video interpretive services. Once implemented, the facility must submit documentation that all staff have been trained on the new practice. The facility must provide the Auditor with the files of 10 detainees received during the Corrective Action Plan (CAP) period to include, if applicable, detainees who do not speak English or Spanish, who are blind or have low vision, deaf or hard of hearing, have intellectual, psychiatric, or speech disabilities, or have limited reading skills to confirm they are provided access to the PREA information in a manner they could understand.

Corrective Action Taken (a)(b): The facility submitted a training email with read receipts which confirms all staff have received training on the updated process which includes the requirements "If you encounter detainees that are blind or have low vision, deaf or hard of hearing, or those who have intellectual, psychiatric or speech disabilities, notify your supervisor and immediately begin soliciting the assistance of the ICE Language Access Services to find addition resources to communicate with these detainees." In addition, a review of the training email further confirmed it included a Lionbridge Translator Service Flyer with instructions to staff to use the language line for all detainees with a disability such as, LEP, blind or hearing impaired; and for detainees who are hearing impaired, the instructions require staff use Lionbridge to translate the documents, allowing the deaf detainee the ability to read the information. The facility submitted a memorandum to the Auditor which confirms the facility has not received any detainees during the CAP period who were limited English proficient. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

§115.118 - Upgrades to facilities and technologies
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(b): ICE Directive 11087.1 states, "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a hold room, the FOD, in coordination with the Office of Facilities Administration, Office of the Chief Financial Officer, shall consider how such technology may enhance the agency's ability to protect detainees from sexual abuse and assault." During an interview with the PSA Compliance Manager, it was indicated the video monitoring equipment was upgraded in October 2022. The PSA Compliance Manager further indicated the camera locations were considered to enhance the Agency's ability to protect detainees from sexual abuse and assault, including but not limited to ensuring detainees could perform bodily functions without being viewed by staff of the opposite gender; however, a review of the submitted HFSAT confirmed the facility indicated no when asked "Has any new monitoring, electronic surveillance, or video equipment been installed in the past year that directly impacts the effectiveness or operations of the holing facility?" A review of the submitted HFSAT further confirmed the facility did not address the HFSAT's requirement to include information on how the Field Office considered the impact of this technology on protecting detainees from sexual abuse or assault.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. During an interview with the PSA Compliance Manager, it was indicated the video monitoring equipment was upgraded in October 2022. The PSA Compliance Manager further indicated the camera locations were considered to enhance the Agency's ability to protect detainees from sexual abuse and assault, including but not limited to ensuring detainees could perform bodily functions without being viewed

by staff of the opposite gender; however, a review of the submitted HFSAT confirmed the facility indicated "no" when asked "Has any new monitoring, electronic surveillance, or video equipment been installed in the past year that directly impacts the effectiveness or operations of the holding facility?" A review of the submitted HFSAT further confirmed the facility did not address the HFSAT's requirement to include information on how the Field Office considered the impact of this technology on protecting detainees from sexual abuse or assault. To become compliant, the facility must submit documentation that confirms when upgrading the video monitoring system, the Field Office considered the impact of the technology on protecting detainees from sexual abuse or assault.

Corrective Action Taken (b): The facility provided the Auditor with a memorandum from the AFOD confirming during the installation of the camera system the facility considered the impact the installation of the technologies would have on the protection and/or prevention of sexual assault or abuse of the ICE detainees held in the ICE El Paso Hold Room. The facility submitted the facility's 2023 HFSAT which confirmed the facility considered the impact the installation of the technologies would have on the protection and/or prevention of sexual assault or abuse of the ICE detainees held in the ICE El Paso Hold Room. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (b) of the standard.

§115.121 - Evidence protocols and forensic medical examinations
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(b)(c)(d): ICE Directive 11087.1 states, "The FOD shall coordinate with ERO HQ and the ICE PSA Coordinator in utilizing, to the extent available and appropriated, community resources and services that provide expertise and support in the areas of crisis intervention and counseling to address victims' needs." In addition, ICE Directive 11087.1 states, "Where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the FOD shall arrange for or refer an alleged victim detainee to a medical facility to undergo a forensic medical examination, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel. If, in connection with an allegation of sexual abuse or assault, the detainee is transported for a forensic examination to an outside hospital that offers victim advocacy services, the detainee shall be permitted to use such services to the extent available, consistent with security needs." The Auditor reviewed a memorandum from the AFOD which indicates, "The IEPHR is a staging facility for administrative processing that typically detains individuals between two to three hours before moving them to a detention center; and therefore, the hold room utilizes the same memorandum of understanding (MOU) as the El Paso Processing Center." The facility provided the Auditor with a Letter of Understanding (LOU) between Tenet Hospitals d/b/a Providence Memorial Hospital, Sierra Medical Center, and the Division of Immigration Health Services (DIHS) which confirms the hospitals would provide emergency medical services to detainees, when needed; however, the Auditor reviewed the LOU and confirmed IEPHR is not included in the agreement. An interview with the PSA Compliance Manager, indicated if a sexual abuse were to occur and emergency medical services were needed, with consent, the detainee would be taken to Sierra Medical Center (SMC); however, the facility did not submit documentation to confirm SMC would provide a forensic exam including a SAFE/SANE or other medical professional at no cost to the detainee and only with the detainee's consent. The PSA Compliance Manager indicated the holding room does not have victim advocacy programs available due to the limited time that detainees are at the facility. There were no allegations of sexual abuse reported at IEPHR during the audit period.

Does Not Meet (b)(c)(d): The facility is not in compliance with subsections (b), (c) and (d) of the standard. The facility provided the Auditor with a "LOU between Tenet Hospitals d/b/a Providence Memorial Hospital, d/b/a Sierra Medical Center and DIHS which indicates the hospitals would provide emergency medical services to detainees, when needed"; however, the Auditor reviewed the LOU and confirmed IEPHR is not included in the agreement. An interview with the PSA Compliance Manager, indicated if a sexual abuse were to occur and emergency medical services were needed, with consent, the detainee would be taken to SMC; however, the facility did not submit documentation to confirm SMC would provide a forensic exam including a SAFE/SANE or other medical professional at no cost to the detainee and only with the detainee's consent. The PSA Compliance Manager indicated the holding room does not have victim advocacy programs available due to the limited time that detainees are at the facility. To become compliant the facility must identify a local hospital to provide the detainee victim a forensic exam, if evidentiarily or medically appropriate, by a SAFE/SANE Nurse or other qualified medical practitioner, at no cost to the detainee, and only with the detainee's consent. In addition, the facility must identify a community resource to provide expertise and support in the areas of crisis intervention and counseling and to provide advocacy services, if not available through the hospital agreement, to the detainee victim during a forensic exam and during the investigation process. The facility must provide documented training to all applicable staff regarding protocols developed and their responsibility to provide the detainee victim with all requirements of the standard. The facility must also provide the Auditor with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subparts (b), (c) and (d) of the standard.

Corrective Action Taken (b)(c)(d): The facility submitted an email which confirms the facility has identified the University Medical Center of El Paso to provide SANE services to a detainee victim of sexual abuse without cost to the detainee victim and would only be provided with the detainee victim's consent. The facility submitted an email which confirms Center Against Sexual and Family Violence (CASFV) advocate services would provide crisis intervention and counseling to appropriately address

a detainee victim's needs. The facility submitted a memorandum to Auditor which states, "As the Assistant Field Officer Director over ICE El Paso Hold Room, I attest that during this audit/corrective action plan period from April 2023 to November 2023, there has not been any sexual abuse allegations of detainees while in ICE custody." The Auditor reviewed the facility PAQ and confirmed there are no medical or mental health staff employed at IEPHR; and therefore, the Auditor no longer requires the facility provide documentation to confirm all medical and mental health staff have received training regarding protocols developed and their responsibility to provide the detainee victim with all requirements of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (b)(c)(d) of the standard.

(e): During an interview with the PSA Compliance Manager, it was indicated that IEPHR does not conduct criminal investigations and if a sexual abuse criminal in nature were to occur the facility would utilize the Fort Bliss Police Department (FBPD) Criminal Investigation Department (CID); however, if FBPD CID refuses to investigate, the facility would notify the EPCSO. IEPHR did not provide the Auditor with documentation to confirm IEPHR has made a request to the FBPD CID or the EPCSO to follow the requirements of paragraphs (a-d) of the standard.

Does Not Meet (e): IEPHR is not in compliance with subsection (e) of the standard. During an interview with the PSA Compliance Manager, he indicated that IEPHR does not conduct criminal investigations. If a sexual abuse criminal in nature were to occur, the facility would utilize FBPD CID; however, if FBPD CID refuses to investigate, the facility would notify the EPCSO. IEPHR did not provide the Auditor with documentation to confirm IEPHR has made a request to the FBPD CID or the EPCSO to follow the requirements of paragraphs (a-d) of the standard. To become compliant, IEPHR must request the FBPD CID and the EPCSO to follow the requirements of paragraphs (a-d) of the standard.

Corrective Action Taken (e): The facility submitted an email from the SDDO to EPCSO to confirm the facility requested EPCSO to follow the requirements of paragraphs (a-d) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (e) of the standard.

§115.131 - Employee, contractor, and volunteer training
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): ICE Directive 11062.2 mandates, "All current employees required to take the training, as listed below, shall provide each employee with biennial refresher training to ensure that all employees know ICE's current sexual abuse policies and procedures, and all newly hired employees who may have contact with individuals in ICE custody shall also take the training within one year of their entrance on duty." ICE Directive 11062.2 further mandates, "All ICE personnel who may have contact with individuals in ICE Custody, including all ERO officers and HSI special agents shall receive training on, among other items: a) ICE's zero-tolerance policy for all forms of sexual abuse and assault; b) The right of detainees and staff to be free from sexual abuse or assault; c) Definitions and examples of prohibited and illegal behavior; d) Dynamics of sexual abuse and assault in confinement; e) Prohibitions on retaliation against individuals who report sexual abuse or assault; f) Recognition of physical, behavioral, and emotional signs of sexual abuse or assault, situations in which sexual abuse or assault may occur, and ways of preventing and responding to such occurrences, including: i) Common reactions of sexual abuse and assault victims; ii) How to detect and respond to signs of threatened and actual sexual abuse or assault; iii) Prevention, recognition, and appropriate response to allegations or suspicions of sexual abuse and assault involving detainees with mental or physical disabilities; and iv) How to communicate effectively and professionally with victims and individuals reporting sexual abuse or assault; g) How to avoid inappropriate relationships with detainees; h) Accommodating limited English proficient individuals and individuals with mental or physical disabilities; i) Communicating effectively and professionally with lesbian, gay, bisexual, transgender, intersex, or gender nonconforming individuals, and members of other vulnerable populations; j) Procedures for fulfilling notification and reporting requirements under this Directive; k) The investigation process; and l) The requirement to limit reporting of sexual abuse or assault to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes." The Auditor reviewed the ICE PREA Virtual University (VU) Training PowerPoint and confirmed that all elements required by the standards are included in the training material. The Auditor reviewed an IEPHR list of facility participants who attended a Teams meeting on November 30, 2022; however, no documentation was provided to confirm the purpose of the Teams meeting was to provide the required PREA training. In addition, no documentation was provided to indicate staff have received refresher training every two years. During an interview with the PSA Compliance Manager, and through Auditor observations, the IEPHR does not enlist the services of contractors or volunteers, who have contact with the detainees.

Does Not Meet (a)(b)(c): IEPHR is not in compliance with subsections (a), (b) and (c) of the standards. The Auditor reviewed an IEPHR list of facility participants who attended a Teams meeting on November 30, 2022; however, no documentation was provided to indicate the purpose of the Teams meeting was to provide the required PREA training. In addition, no documentation was provided to indicate staff have received refresher training every two years. To become compliant, IEPHR must provide documentation that confirms all ICE staff have received the refresher training required by subsection (a) of the standard.

Corrective Action Taken (a)(b)(c): The facility submitted a course description for ICE PREA training. The Auditor reviewed the course curriculum and confirmed ICE PREA training includes all elements required by subsection (a) of the standard. The facility submitted a training roster which confirms all ICE staff have completed the required training. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

§115.132 - Notification to detainees of the agency's zero-tolerance policy
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

ICE Directive 11062.2, mandates, "The FOD shall ensure that key information regarding ICE's zero-tolerance policy for sexual abuse and assault is visible or continuously and readily available to detainees (e.g., through posters, detainee handbooks, or other written formats)." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice posted in the intake processing area and in each of the holding cells. The posters included the name of the IEPHR PSA Compliance Manager; however, were English and Spanish only. In addition, the Auditor observed the ICE National Detainee Handbook in the processing area, available in both English and Spanish. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video recording of two detainees being processed at the facility and confirmed neither detainee had been given any written material. During the onsite audit, the Auditor further observed the facility did not have the DHS-prescribed SAA Information pamphlet readily available onsite or a process in place to ensure the information contained in the pamphlet is provided to the detainees. IEPHR had obtained the pamphlet in the 15 languages most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the written information included in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. Interviews with four DDOs, confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or had low vision, had limited reading skills, or had an intellectual, psychiatric, or speech disability. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or had a similar disability the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. The Auditor reviewed the Agency website (www.ice.gov) and confirmed the Agency's zero-tolerance policy has been made available to the public. No detainees were present at the time of the on-site audit; and therefore, no detainee interviews were conducted.

Does Not Meet: The facility is not in compliance with the standard. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice posted in the intake processing area and in each of the holding cells. The posters included the name of the IEPHR PSA Compliance Manager; however, were in English and Spanish only. In addition, the Auditor observed the ICE National Detainee Handbook in the intake processing area, available in both English and Spanish only. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer, and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video recording of two detainees being processed at the facility and confirmed neither detainee had been given any written material. During the onsite audit, the Auditor confirmed the facility did not have the DHS-prescribed SAA Information pamphlet readily available onsite for distribution. IEPHR had obtained the pamphlet in the 15 most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese prior to exiting the facility; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the information contained in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. Interviews with four DDOs, confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or had low vision, had limited reading skills, or an intellectual, psychiatric, or speech disability. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or had a similar disability the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. To become compliant the facility must institute a practice that provides all detainees with key PREA information regarding the Agency's zero-tolerance policy, including detainees whose preferred language is other than English or Spanish, and are either developmentally or physically disabled. Once implemented, the facility must train all intake staff on the new practice and document the training. The facility must provide the Auditor with the files of 10 detainees received during the CAP period to include, if applicable, detainees who do not speak English or Spanish, who are blind or have low vision, deaf or hard of hearing, have intellectual, psychiatric, or speech disabilities, or have limited reading skills to confirm they are provided access to the PREA information in a manner they could understand.

Corrective Action Taken: The facility submitted a training email with read receipts which confirms all staff have received training on the updated process which includes the requirements "If you encounter detainees that are blind or have low vision, deaf or hard of hearing, or those who have intellectual, psychiatric or speech disabilities, notify your supervisor and immediately begin soliciting the assistance of the ICE Language Access Services to find addition resources to communicate with these detainees." In addition, a review of the training email further confirmed it included a Lionbridge Translator Service Flyer with instructions to staff to use the language line for all detainees with a disability such as LEP, blind or hearing impaired and for detainees who are hearing impaired; the instructions require staff use Lionbridge to translate the documents, allowing the deaf detainee the ability to read the information. The facility submitted a memorandum to the Auditor which confirms the facility has not received any detainees during the CAP period who were limited English proficient. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with standard 115.132.

§115.141 - Assessment for risk of victimization and abusiveness
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(c)(d)(e): ICE Directive 11087.1 states, "The FOD should ensure that before placing detainees together in a hold room, there shall be consideration of whether a detainee may be at a high risk of being sexually abused or assaulted, and, when appropriate, shall take necessary steps to mitigate any such danger to the detainee." ICE Directive 11087.1 further states, "For detainees identified as being at high risk for victimization, the FOD shall provide heightened protection, including continuous direct sight and sound supervision, single-housing, or placement in a hold room actively monitored on video by a staff member sufficiently proximate to intervene, unless no such option is feasible. The FOD shall implement appropriate controls on the dissemination of any sensitive information regarding a detainee provided pursuant to screening procedures." In addition, ICE Directive 11087.1 states, "The FOD shall ensure that the following criteria are considered in assessing detainees for risk of sexual victimization, to the extent that the information is available: Whether the detainee has a mental, physical, or developmental disability; The age of the detainee; The physical build and appearance of the detainee; Whether the detainee has previously been incarcerated or detained; The nature of the detainee's criminal history; Whether the detainee has any convictions for sex offenses; Whether the detainee has self-identified as Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI) or gender nonconforming; Whether the detainee has self-identified as previously experiencing sexual victimization; and The detainee's own concerns about his or her physical safety." In interviews with 4 DDOs it was indicated detainees are not held over 12 hours at IEPHR however, should a detainee need to be held at the facility longer he/she would be transferred to the El Paso Processing Center for housing. In interviews with the PSA Compliance Manager and four DDOs, it was indicated a detainee's risk is assessed by using the Risk Classification Assessment Worksheet (RCA). The Auditor reviewed the RCA worksheet and confirmed it includes the detainee's age, physical and mental disabilities, risk based on sexual orientation, gender identity, whether they are a victim of sex trafficking or have experienced past sexual abuse; however, the Auditor reviewed the submitted HFSAT which confirmed IEPHR only takes into consideration a detainee's gang affiliation, age, criminal history, gender, medical conditions, and physical stature to determine a detainee's risk of sexual victimization prior to placing him/her in a holding cell and not the entirety of information provided on the RCA. The Auditor observed the RCA on the facility computer system and verified that the information is properly controlled with user Ids and passwords. During the on-site audit, the Auditor observed the processing area including the holding cells and confirmed each holding cell had a large observation window, allowing the officers to see the entire cell at all times; and therefore, if a detainee was a high risk for victimization, the facility would have continuous direct sight and sound of the detainee. In interviews with four random DDOs it was indicated if according to a detainee's risk assessment, or if the detainee had concerns about their safety, they would be placed in a holding cell by themselves. During the onsite audit, the Auditor reviewed a video recording of two detainees processed at IEPHR the previous day. The Auditor observed staff conducting the RCA with each detainee and that both detainees were at the facility for less than 30 minutes.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. In interviews with the PSA Compliance Manager and four DDOs, it was indicated a detainee's risk is assessed by using the Risk Classification Assessment Worksheet (RCA). The Auditor reviewed the RCA worksheet and confirmed it includes the detainee's age, physical and mental disabilities, risk based on sexual orientation, gender identity, whether they are a victim of sex trafficking or have experienced past sexual abuse; however the Auditor reviewed the submitted HFSAT which confirmed IEPHR only takes into consideration a detainee's gang affiliation, age, criminal history, gender, medical conditions, and physical stature to determine a detainee's risk of sexual victimization prior to placing him/her in a holding cell and not the entirety of information provided on the RCA. To become compliant the IEPHR must consider all information available to the facility on the RCA and not just a detainee's gang affiliation, age, criminal history, gender, medical conditions, and physical stature as indicated on the submitted HFSAT to determine a detainee's risk of sexual victimization prior to placing him/her in a holding cell. In addition, the facility must document that all DDOs are trained on the standard's requirement. The facility must submit to the Auditor 10 files of detainees who arrived during the CAP period to confirm all elements of the RCA are being considered in determining a detainee's risk of sexual victimization prior to placing him/her in a holding cell.

Corrective Action Taken (c): The facility submitted one PREA initial assessment which confirms the facility has implemented a practice to consider all information available to the facility on the RCA when determining a detainee's risk of sexual victimization prior to placing him/her in a holding cell. The Auditor reviewed the submitted PREA Initial Assessment and accepts

the document for confirmation; and therefore, no longer requires the facility submit to the Auditor 10 files of detainees who arrived during the CAP period. The facility submitted emails to all staff which confirm the facility has submitted direction to staff to consider all information available to the facility on the RCA to determine a detainee's risk of sexual victimization prior to placing him/her in a holding cell. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115.151 - Detainee reporting

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

Notes:

(a)(b)(c): ICE Directive 11087.1 states, "a) The FOD shall ensure that detainees are provided instruction on how they can privately report incidents of sexual abuse or assault, retaliation of reporting sexual abuse or assault, or staff neglect or violations of responsibilities that may have contributed to such incidents to ERO personnel. b) The FOD shall implement procedures for ERO personnel to accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports." During the onsite audit, the Auditor observed the DHS-prescribed sexual abuse awareness notice posted in the intake processing area and in all holding cells in English and Spanish only. The signage provided information on how to make an anonymous call and how to contact the ICE ERO Detention Reporting and Information Line (DRIL) and the DHS OIG; however, there were no telephones available for a detainee to utilize the telephone numbers provided. When asked how a detainee would be able to call, a DDO reported the detainee would be allowed to utilize the telephone at the DDOs workstation; however, the DDO would remain in the area during the call. Interviews with the four DDOs indicated that the ICE National Detainee Handbook is available on-site in English and Spanish. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video of two detainees being processed at IEPHR and confirmed neither detainee was provided with any written materials. During the onsite audit the Auditor observed the facility did not have the DHS-prescribed SAA Information pamphlet readily available or a process in place to ensure the information contained in the pamphlet is provided to the detainees. Interviews with the PSA Compliance Manager and four DDO's indicated detainees are able to report an incident of sexual abuse, retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. The four DDOs were able to articulate they are required to accept and report allegations made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports.

Does Not Meet (a)(b): IEPHR is not in compliance of subsections (a) and (b) of the standard. During the onsite audit, the Auditor observed the DHS-prescribed sexual abuse awareness notice posted in the intake processing area and in all holding cells in English and Spanish only. The signage provided information on how to make an anonymous call and to contact the DRIL and the DHS OIG; however, there were no telephones available for the detainees to utilize the telephone numbers provided. When asked how a detainee would be able to complete a DDO reported the detainee would be allowed to utilize the telephone at the DDOs workstation; however, there were no telephones available for the detainees to utilize the telephone numbers provided. When asked how a detainee would be able to complete a DDO reported the detainee would be allowed to utilize the telephone at the DDOs workstation; however, the DDO would remain in the area during the call. Interviews with the four DDOs indicated that the ICE National Detainee Handbook is available on-site in English and Spanish. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video of two detainees being process at IEPHR and confirmed neither detainee was provided with any written materials. During the onsite audit, the Auditor observed the facility did not have the DHS-prescribed SAA Information pamphlet readily available or a process in place to ensure the information contained in the pamphlet is provided to the detainees.

Corrective Action Taken (a)(b): The facility submitted a copy of a posting which confirms the facility has established a procedure to instruct detainees on how to contact the DHS OIG anonymously. The facility submitted an email to all staff with read receipts to confirm all staff have received training on the updated procedure. The facility submitted photos to confirm a copy of a notification on how to contact the DHS OIG anonymously has been posted. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

§115.165 - Coordinated response

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

Notes:

(a)(b)(c): ICE Directive 11087.1 states, "The FOD shall ensure a coordinated, multidisciplinary team approach to responding to allegations of sexual abuse and assault occurring in holding facilities, or in the course of transit to or from holding facilities, as well as to allegation made by a detainee at a holding facility of sexual abuse or assault that occurred elsewhere in ICE custody." ICE Directive 11087.1 further states, "If a victim is transferred from a holding facility to a detention facility or to a non-ICE

facility, the FOD shall inform the receiving facility of the indecent and the victim's potential need for medical or mental health care of victim services." A review of ICE Directive 11087.1 confirms it does not include "unless the victim requests otherwise." Interviews with four DDOs, confirmed their knowledge of first responder duties. Each DDO could articulate they would call for back up, separate the victim and abuser, protect the crime scene, and request the victim not take any actions that could destroy evidence or allow the abuser to take any action that could destroy evidence. In an interview, the PSA Compliance Manager confirmed if a detainee being transferred was a victim of sexual abuse, IEPHR staff would provide the receiving facility any information regarding the sexual abuse allegation, including the victim's need for any medical or social services follow-up and if the victim was transferred to a non-DHS facility, with the consent of the victim detainee, the same information would be provided to the receiving facility; however, the standard requires the detainee's consent should the detainee be transferred to a facility not covered by DHS PREA standards and not to non-DHS facilities. There were no allegations of sexual abuse reported at IEPHR during the reporting period.

Does Not Meet (c): ICE Directive 11087.1, as it relates to standard 115.165 is not consistent with the standard. The Directive as it relates to the coordinated response protocol does not include "unless the victim requests otherwise." Although Agency Directive, 11062.2 is compliant with the DHS PREA Standards, if hold rooms are using 11087.1 as their coordinated response protocol, or even a combination of both, then they would be deficient. In addition, in an interview with the PSA Compliance Manager it was confirmed if the victim was transferred to a non-DHS facility, with the consent of the victim detainee, the facility would provide the receiving any information regarding the sexual abuse allegation, including the victim's need for any medical or social services follow-up; however, the standard requires the detainee's consent should the detainee be transferred to a facility not covered by DHS PREA standards and not to non-DHS facilities. To become compliant, the Agency must update their written institutional plan to contain the required verbiage as written in 115.165 subpart (c). The facility must provide documented training of applicable staff on the updated written institutional plan to include the PSA Compliance Manager. If applicable, the facility must provide the Auditor with any investigation, medical, and detainee files regarding any detainee victim of sexual abuse transferred from IEPHR during the CAP period.

Corrective Action Taken (c): The facility submitted a HQ broadcast dated 9/8/2022 which includes subsection (b) If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the agency shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services. (c) If a victim is transferred from a DHS holding facility to a facility not covered by paragraph (b) of this section, the agency 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. In addition, the facility provided the Auditor with an email dated October 27, 2023, with read receipts which confirmed all staff received a copy of the HQ Broadcast. The facility submitted a memorandum to the Auditor which confirms the facility has not had an allegation of sexual abuse during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard 115.165.

§115.182 - Access to emergency medical services
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): ICE Directive 11087.1 states, "The FOD shall ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The FOD shall coordinate with ERO HQ, and the Agency PSA Coordinator, in utilizing, to the extent available, any community resources and services that provide expertise and support in the areas of crisis intervention and counseling to address the victims' needs." ICE Directive 11087.1 further states, "Victims of sexual abuse shall be provided emergency medical and mental health services and any ongoing care necessary. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The Auditor reviewed a memorandum from the AFOD which indicates that the IEPHR is a staging facility for administrative processing that typically detains individuals between two to three hours before moving them to a detention center. The hold room utilizes the same memorandum of understanding as the El Paso Processing Center. The facility provided the Auditor with a "LOU between Tenet Hospitals d/b/a Providence Memorial Hospital and d/b/a Sierra Medical Center and DIHS which indicates the hospitals would provide emergency medical services to detainees, when needed"; however, the Auditor's review of the LOU confirmed, IEPHR is not included. An interview with the PSA Compliance Manager indicated if a sexual abuse were to occur and emergency medical services were needed, the detainee would be taken to SMC. The Auditor was not provided documentation to confirm that SMC would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and at no financial cost to the victim detainee regardless of if the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, IEPHR has not provided documentation to confirm in the event of an incident of sexual abuse, the victim would be offered support services to include crisis intervention and counseling. There were no sexual abuse allegations reported at the IEPHR during the audit period.

Does Not Meet (a)(b): IEPHR is not in compliance with subsections (a) and (b) of the standard. The facility provided the Auditor with a LOU between Tenet Hospitals d/b/a Providence Memorial Hospital and d/b/a Sierra Medical Center and DIHS

which indicates the hospitals would provide emergency medical services to detainees, when needed; however, the Auditor's review of the LOU confirmed IEPHR is not included. An interview with the PSA Compliance Manager, indicated if a sexual abuse were to occur and emergency medical services were needed, the detainee would be taken to SMC. The Auditor was not provided documentation to indicate that SMC would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and at no financial cost to the victim detainee regardless of if the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, IEPHR has not provided documentation to confirm in the event of an incident of sexual abuse, the victim would be offered support services to include crisis intervention and counseling. To become compliant, IEPHR must coordinate with a community resource to provide expertise and support to include crisis intervention and counseling. In addition, the IEPHR must provide documentation that confirms SMC or another entity would provide detainee victims of sexual abuse timely, unimpeded access to emergency medical treatment, including emergency contraceptives and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and at no financial cost to the victim detainee regardless if the victim names the abuser or cooperates with an investigation arising out of an incident of sexual abuse. IEPHR must provide documented training to all applicable staff regarding their responsibility to provide the detainee victim with all requirements of the standard. If applicable, IEPHR must provide the Auditor with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (a) and (b) of the standard.

Corrective Action Taken (a)(b): The facility submitted an email which confirms the facility has identified the University Medical Center of El Paso to provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and at no financial cost to the victim detainee regardless of if the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. The facility submitted training emails with read receipts which confirm the facility has submitted direction to staff regarding their responsibility to provide the detainee victim with all requirements of the standard. The facility submitted a memorandum to the Auditor which states, "As the Assistant Field Officer Director over ICE El Paso Hold Room, I attest that during this audit/corrective action plan period from April 2023 to November 2023, there has not been any sexual abuse allegations of detainees while in ICE custody." The Auditor reviewed the facility PAQ and confirmed there are no medical or mental health staff employed at IEPHR; and therefore, the Auditor no longer requires the facility provide documentation to confirm all medical and mental health staff have received training regarding protocols developed and their responsibility to provide the detainee victim with all requirements of the standard. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) and (b) of the standard.

§115.193
Outcome: Low Risk
Notes:

This is the second PREA audit for IEPHR. IEPHR only holds detainees up to 12 hours, and there has not been an allegation of sexual abuse between June 14, 2018, through December 2, 2023. During the on-site audit, the Auditor observed staff conducting rounds, walking up to the door, and visually observing detainees in the holding cells. After a careful review of the corrective action taken, it is determined the facility is in compliance with all previously deficient standards; and now in 100% compliance with the DHS PREA Standards. Therefore, the Auditor has determined the facility is low risk.

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 December 20, 2023
Auditor's Signature & Date

(b) (6), (b) (7)(C) December 21, 2023
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) December 22, 2023
Program Manager's Signature & Date

PREA Audit: Subpart B
DHS Holding & Staging Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	4/11/2023	**To:**	4/12/2023
AUDITOR INFORMATION			
Name of auditor:	Robin M. Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	ERO El Paso Field Office
Field Office Director:	Mary De Anda-Ybarra
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	11541 Montana Avenue, Suite E, El Paso, Texas 79936
Mailing address: (if different from above)	Same as above

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	ICE El Paso Hold Room		
Physical address:	11541 Montana Avenue, Suite E, El Paso, Texas 79936		
Mailing address: (if different from above)	Same as above		
Telephone number:	915-856-5504		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Field Office Director (FOD)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	915-856-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer (SDDO)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	915-269-(b) (6), (b)

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	01/06/2023
Notes:	N/A

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the ICE El Paso Hold Room (IEPHR) was conducted April 11-12, 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 the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility's compliance with the DHS PREA Standards. This audit is the second audit for IEPHR, and includes a review of the period between June 14, 2018, through April 12, 2023.

IEPHR is operated by DHS ICE, Enforcement and Removal Operations (ERO). IEPHR has a design capacity of 52, and currently holds adult male and female detainees for processing prior to relocation to another facility, the Bridge of Americas for deportation, or release to the street. Detainees are normally held at the facility for approximately fifteen minutes; however, the hold has been extended to approximately two hours. Detainees are never housed overnight or kept for longer than 12 hours. If the hold would exceed 12 hours, the detainee would be transported to El Paso Processing Center. If a detainee is transported to IEPHR by means of ICE DDO apprehension, the detainee is processed, printed, and receives a Risk Classification Assessment (RCA) that will follow him/her to their next destination. IEPHR does not house juveniles. During the last 12 months there were 158 adult detainees: 144 males and 14 females processed through the IEPHR. The facility is located in El Paso, Texas. Approximately four weeks prior to the on-site audit the ERAU Team Lead (TL), (b) (6), (b) (7)(C), provided the completed Pre-Audit Questionnaire (PAQ) along with supporting documents and policies for the IEPHR through the ICE SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and the Document Request DHS Immigration Detentions Facilities form and placed within folders for ease of auditing. The Auditor reviewed all documentation provided to identify gaps, or issues, prior to conducting the on-site audit of the facility. The main policies that provide facility direction for IEPHR are ICE Directive 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI) and ICE Directive 11087.1 Operation of ERO Holding Facilities. All documentation, policies, and the facilities PAQ's were reviewed by the Auditor. In addition, the Auditor reviewed the Agency website, www.ice.gov.

On Tuesday, April 11, 2023, at 8:15 a.m. an entrance briefing was conducted in a facility conference room. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance, were:

(b) (6), (b) (7)(C), Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU
(b) (6), (b) (7)(C), ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), SDDO/Prevention of Sexual Abuse (PSA) Compliance Manager, ICE/ERO
(b) (6), (b) (7)(C), SDDO, ICE/ERO
(b) (6), (b) (7)(C), SDDO, ICE/ERO
(b) (6), (b) (7)(C), SDDO, ICE/ERO
(b) (6), (b) (7)(C), Detention and Deportation Officer (DDO), ICE/ERO
Robin Bruck, Certified DOJ/DHS 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. 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 knowledge of staff of all levels and detainees, housed within the facility. She further explained compliance with the PREA standards will be determined based on a review of the policies and procedures, observations during the on-site audit, documentation review, and interviews with staff and detainees. At the conclusion of the entrance briefing, an on-site tour of the holding room was conducted by the Auditor, ICE TL, and key IEPHR staff. The Auditor observed three holding cells, a booking area with workstations, sally port, control room, staff kitchen/lunch break room, interview rooms and staff offices. During the on-site audit, the Auditor looked at camera placements, blind spots, and detainee to staff ratio in accordance with the capacity of the holding room. In addition, the Auditor looked for the detainee's ability to perform bodily functions without being viewed by the staff of the opposite gender. There were no showers or changing areas within the hold room.

IEPHR operates with three shifts 0600-1400, 1400-2200, and 2200-0600. All processing staff are ICE DDOs (22 male and 3 female). There are no contract employees or volunteers who may have continuing contact with detainees that provide services at IEPHR. The Auditor conducted a total of five formal interviews, which included the PSA Compliance Manager and four DDOs. The Auditor observed the PREA audit notification, DHS Office of Inspector General (OIG) poster, and the DHS-prescribed sexual assault awareness notice, which contained the name of the facility PSA Compliance Manager, posted in all hold rooms and the processing area posted in English and Spanish only. No correspondence was received from detainees, staff, or other individuals during the pre-audit, on-site audit, or post on-site audit. The facility did not receive detainees during the on-site audit; however, the Auditor observed a video recording

from the previous day consisting of detainees going through the intake process. A review of the video confirmed the detainees were immediately processed and released.

Each holding cell included a toilet, with a wall blocking incidental viewing and concrete benches, which surrounded the perimeter of the cell. All holding cells contained verbiage on the walls in both English and Spanish informing detainees how to report sexual abuse via the phone, in writing, and anonymously; however, there were no phones in the holding cells. (b) (7)(E) From the (b) (7)(E) Detainees do not shower or change clothing at IEPHR.

Informal interviews with facility processing staff indicated when the hold room is occupied supervision is provided by at least two ICE DDOs. Each holding cell has a large observation window allowing staff full view of the holding cells from the DDO workstations. Building security and the control center is maintained by contract staff employed by Paragon; however, they do not have contact with detainees.

On Wednesday, April 12, 2023, at 9:00 a.m., an exit briefing was held in an interview room to discuss the audit findings. The ERAU TL opened the meeting and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C), ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), Assistant Field Office Director (AFOD), ICE/ERO, via telephone
(b) (6), (b) (7)(C), SDDO/PSA Compliance Manager, ICE/ERO
Robin Bruck, Certified DOJ/DHS Auditor, Creative Corrections, LLC.

The Auditor spoke briefly about the staff and detainee knowledge of the IEPHR PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit and that she would need to review all submitted documentation and interview notes conducted with staff and detainees and thanked all present for their cooperation. The ERAU TL explained the audit report process and 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 Not Applicable: 1
§115.114 Juveniles and family detainees

Number of Standards Exceeded: 0

Number of Standards Met: 18
§115.111 Zero-tolerance of sexual abuse
§115.117 Hiring and promotion decisions
§115.122 Policies to ensure investigation of allegations and appropriate agency oversight
§115.134 Specialized training: Investigations
§115.154 Third-party reporting
§115.161 Staff reporting duties
§115.162 Protection duties
§115.163 Reporting to other confinement facilities
§115.164 Responder duties
§115.166 Protection of detainees from contact with alleged abusers
§115.167 Agency protection against retaliation
§115.171 Criminal and administrative investigations
§115.172 Evidentiary standard for administrative investigations
§115.176 Disciplinary sanctions for staff
§115.177 Corrective action for contractors and volunteers
§115.186 Sexual abuse incident reviews
§115.187 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 11
§115.113 Detainee supervision and monitoring
§115.115 Limits to cross-gender viewing and searches
§115.116 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.118 Upgrades to facilities and technologies
§115.121 Evidence protocol and forensic medical examinations
§115.131 Employee, contractor, and volunteer training
§115.132 Notification to detainees of the agency's zero-tolerance policy
§115.141 Assessment for risk of victimization and abusiveness
§115.151 Detainee reporting
§115.165 Coordinated response
§115.182 Access to emergency medical services

Staging Facility Risk Rating:
§115.193 Audits of standards – Not Low Risk

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.

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

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

Notes:

(a): ICE Directive 11062.2 states, "ICE has a zero-tolerance policy for all forms of sexual abuse or assault. It is ICE policy to provide effective safeguards against sexual abuse and assault of all individuals in ICE custody, including with respect to screening, staff training, detainee education, response and intervention, medical and mental health care, reporting, investigation, and monitoring and oversight, as outlined in this Directive, in all requirements of PBNDS 2011 Standard 2.11, and in other related detention standards and ICE policies." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice posted in the intake processing area and in all holding cells. An interview with the PSA Compliance Manager indicated the policy towards all forms of sexual abuse is followed at the holding facility. Interviews with four DDOs confirmed they were familiar with the facility zero-tolerance and their roles and responsibilities to help prevent, detect, and respond to sexual abuse.

§115.113 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): ICE Directive 11087.1 states, "The FOD shall ensure that each holding facility maintains sufficient supervision of detainees, including through appropriate staffing levels and where applicable, video monitoring, to protect detainees against sexual abuse and assault. In so doing the FOD shall take into consideration a) The physical layout of each holding facility; b) The composition of the detainee population; c) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; d) The findings and recommendations of the sexual abuse review reports; e) Any other relevant factors, including the length of time detainees spend in custody at the holding facility. The FOD shall ensure that detainees placed into the holding facilities are subject to direct supervision, which shall include (b) (7)(E) [redacted] In addition, ICE Directive 11087.1 further states, "The FOD shall at least annually review the application of this policy at each holding facility within his or her AOR to ensure ongoing compliance." According to the PAQ there are 31 staff employed at IEPHR, which includes 24 male DDOs and 7 female DDOs; however, during the on-site audit, the facility reported a total of 30 staff positions, which includes an AFOD, 4 SDDOs, and 25 DDOs (22 male and 3 female), to cover 3 shifts, 0600-1400, 1400-2200, and 2200-0600. An interview with the PSA Compliance Manager indicated, during detainee processing, there are always two DDOs present to monitor the detainees. In addition, the PSA Compliance Manager indicated when determining adequate staffing levels and the need for video monitoring, the Agency will consider the physical layout of the holding facility, the composition of the detainee population, the length of time detainees spend in the Agency custody, and any other relevant factors. In addition, the PSA Compliance Manager indicated the Agency would consider substantiated or unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other factors; however, the facility has not had a reported sexual abuse allegation. While on-site the Auditor observed three holding cells. Each holding cell had large observation windows that allowed for DDOs to have the ability to see the entirety of the hold rooms from their workstations. In addition, (b) (7)(E) [redacted] . There are a total of (b) (7)(E) [redacted] . (b) (7)(E) [redacted] . IEPHR provided the Auditor the facility Hold Facility Self-Assessment Tool (HFSAT), dated 12/13/2017; however, this process is required to be completed annually. The document's purpose states, "It is used to determine if the facility maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse"; however, a review of the HFSAT confirms it does not include documentation to confirm the Agency took into consideration the elements required by subsection (c) of the standard when determining adequate staffing or the need for video monitoring or the supervision guidelines were reviewed to determine their application at IEPHR for the years 2022 or 2023. In addition, a review of the HFSAT confirms it states, "according to Section 4.1 of the Holding Facilities Directive, personnel will perform physical hold room checks at least every 15 minutes. These checks will be logged, including the time of each check and any important observations on the Holding Facility Inspection Log"; however, interviews with four DDOs confirmed due to the open construction of the holding facility, which allows for maximum viewing of all holding cells at all times, physical hold room checks are not conducted at IEPHR.

Does Not Meet (b) and (c): IEPHR is not in compliance with subsections (b) and (c) of the standard. An interview with the PSA Compliance Manager indicated when determining adequate staffing levels and the need for video monitoring, the Agency would consider the physical layout of the holding facility, the composition of the detainee population, substantiated or unsubstantiated incidents of sexual abuse, the length of time detainees spend in the Agency custody, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors; however, a review of the HFSAT confirms it does not include documentation to confirm the Agency took into consideration the elements required by subsection (c) of the standard when

determining adequate staffing or the need for video monitoring. In addition, a review of the HFSAT could not confirm that the Agency developed comprehensive supervision guidelines or that the supervision guidelines were reviewed to determine their application at IEPHR for the years 2022 or 2023. To become compliant the facility must provide documentation that the Agency took into consideration the physical layout of each 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 agency custody when determining adequate supervision or the need for video monitoring. In addition, the facility must provide the Auditor with documentation to confirm that the supervision guidelines were reviewed during the last year as required by subsection (b) of the standard.

Recommendation: The Auditor recommends that IEPHR staff conduct physical hold room checks every 15 minutes as required by ICE Directive 11087.1.

§115.114 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): The Auditor reviewed a memorandum, dated February 27, 2023, which states, "Concerning 115.114, Exhibit 3, Juvenile and Family detainees, the El Paso Hold room (Co-Location) does not house juveniles or families and has not done so in the last year." Interviews with the PSA Compliance Manager and four DDOs confirmed IEPHR has not processed any juveniles or families during the audit period.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(c)(e)(f): ICE Directive 11087.1 states, "Strip and Visual Body Cavity Searches - The FOD shall ensure that when pat down searches indicate the need for a more thorough search, an extended search (i.e., strip search) is conducted in accordance with ICE policies and procedures, including that: a) All strip searches and visual body cavity searches are documented; b) Cross-gender strip searches or cross-gender visual body cavity searches are not conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners; and c) Visual body cavity searches of minors are conducted by a medical practitioner and not by law enforcement personnel." ICE Directive 11087.1 further states, "The FOD shall ensure that ERO personnel do not search or physically examine a detainee for the sole purpose of determining the detainee's gender. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records (if available), or, if necessary, learning that information as part of a broader medical examination conducted in private, by a medical practitioner." In addition, ICE Directive 11087.1 states, "The FOD shall ensure that all pat-down searches are conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and ICE policy, including consideration of officer safety. Where operationally feasible, an officer of the same gender as the detainee will perform the pat down search." Interviews with the PSA Compliance Manager and four DDOs indicated that strip searches, cross-gender strip searches, and cross-gender visual body cavity searches are not conducted at the facility. If there were exigent circumstances, which required a strip search or a visual body cavity search, the detainee would be taken to El Paso Processing Center for medical personnel to perform the search. Interviews with four DDOs further confirmed as the strip/body cavity search was being conducted at El Paso Processing Center they would be responsible for documenting the search. The Auditor reviewed the facility Cross-Gender, Transgender, and Intersex Searches training curriculum and confirmed it includes the requirement that all searches shall be performed in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. In addition, the training curriculum includes the requirements at no time shall any search be conducted solely for the purpose of determining a detainee's genital characteristics or gender and if the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination at intake or other processing procedures conducted in private, by a medical practitioner." The Auditor was provided a list of facility participants who attended a Teams meeting. The documentation indicated the date and time each staff member joined the Teams meeting; however, no documentation was provided to indicate the purpose of the Teams meeting or what the meeting entailed; and therefore, the Auditor could not confirm staff have received the required training. Interviews with four DDO's indicated cross-gender pat-down searches are not conducted at IEPHR as female staff from Homeland Security Investigations (HSI) would be available to conduct the search if no IEPHR female staff were on duty should a pat-down search be necessary; however, should the need occur, they would be documented. Interviews with four DDOs further confirmed they were aware you could not search or physically examine a detainee for the sole purpose of determining the detainee's gender; however, each DDO struggled with how to conduct a pat-down search of a transgender/intersex detainee or who should conduct the search. In addition, interviews with four DDOs confirmed they could not articulate that the search must be done in a professional and respectful manner. As detainees are pat-down searched prior to being processed at IEPHR, there were no pat-down searches or available video of pat-down searches for the Auditor to observe.

Does Not Meet (f): IEPHR is not in compliance with subsection (f) of the standard. The Auditor was provided a list of facility participants who attended a Teams meeting. The documentation indicated the date and time each staff member joined the Teams meeting; however, no documentation was provided to indicate the purpose of the Teams meeting or what the meeting entailed; therefore, the Auditor could not confirm staff have received the required training. Interviews with four DDO's confirmed each DDO struggled with how to conduct a pat-down search of a transgender/intersex detainee or who should conduct the search. In addition,

interviews with four DDOs confirmed they could not articulate the search must be done in a professional and respectful manner. To become compliant, the facility must provide the Auditor with documentation that confirms all IEPHR SDDOs and DDOs have received training in the proper procedures for conducting pat-down searches, including how to conduct a pat-down search of a transgender/intersex detainee, who should conduct the search of a transgender/intersex detainees, and the search must be done in a professional and respectful manner. (d): ICE Directive 11087.1 states, "The FOD shall ensure that detainees are permitted to shower (where showers are available), perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine hold room checks, or is otherwise appropriate in connection with a medical exam or monitored bowel movement under medical supervision." ICE Directive 11087.1 further states, "The FOD will also ensure that ERO personnel of the opposite gender announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." During the on-site audit, the Auditor observed that each hold room had large observation windows, which allowed the DDOs to see the entirety of the rooms. A toilet area was observed in each hold room and was blocked by a wall that had sufficient height and length to prevent viewing by staff of the opposite gender when the detainees are utilizing the toilet. In addition, the Auditor observed (b) (7)(E) [redacted] he hold rooms did not have showers or changing areas.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): ICE Directive 11087.1 states, "The FOD shall take appropriate steps to ensure that the detainees with disabilities have an equal opportunity to participate in and benefit from the processes and procedures in connection with placement in an ERO holding facility, consistent with established statutory, regulator, DHS and ICE policy requirements." ICE Directive 11087.1 further states, "The FOD shall take reasonable steps to ensure meaningful access to detainees who are limited English proficient, consistent with established regulatory and DHS and ICE policy requirements." ICE Directive 11062.2 states, "In matters relating to allegations of sexual abuse or assault, ensure the provision of in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretations, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS Policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse or assault, and detainees who have a significant relationship with the alleged abuser, is not appropriate in matters relating to allegations of sexual abuse or assault." Interviews with the PSA Compliance Manager and four random DDOs indicated that IEPHR utilizes the services of ERO Language Services, provided by Lionbridge, to communicate with those detainees who are limited English proficient (LEP). Interviews with the PSA Compliance Manager and four DDOs further indicated they were aware of the availability and location of the instructions for utilizing the line and advised the Lionbridge flyer with instructions for accessing the language line was located in the processing area which was confirmed by the Auditor. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice in English and Spanish in the intake processing area and in each hold room. In addition, the Auditor observed the ICE National Detainee Handbook in the processing area, in both English and Spanish. In interviews with four DDOs, it was indicated should a detainee speak a language other than English or Spanish, they would access the facility computer to print the ICE National Detainee Handbook in the required language. The Auditor reviewed the facility computer and confirmed the facility has access to the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor observed the facility did not have the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet onsite. During the onsite audit IEPHR obtained the pamphlet in the 15 most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the written information included in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. Interviews with four DDOs confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or low vision, had limited reading skills, or had an intellect, psychiatric, or speech disability. During the on-site audit, the Auditor confirmed the facility does not have access to written material, in-person, telephonic or video interpretive services that enable effective and accurate communication with detainees who may suffer from these types of disabilities. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or otherwise disabled the IEPHR would be notified prior to the detainee being transported to the holding room for processing and the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. During the on-site audit, the facility did not receive a detainee for processing; however, the Auditor reviewed a video recording of two detainees being processed at the facility the day prior to the on-site audit. A review of the video confirmed both detainees were at the facility for less than 30 minutes with one detainee being placed in a holding cell for less than five minutes and one detainee not being placed in a holding cell. Neither detainee had been given any written documentation during the process. In interviews with four DDOs it was indicated if a sexual abuse were to occur in the hold room, staff would not utilize another detainee (minor or adult), a detainee who witnessed the alleged abuse, the abuser or those who have a significant relationship with the alleged abuser, for interpretation services on sexual abuse matters and if the alleged victim expressed a preference for another detainee to provide the service, staff would notify the supervisor to ensure that interpretation is appropriate and consistent with DHS policy.

Does Not Meet (a)(b): IEPHR is not in compliance with subsections (a) and (b) of the standard. During the onsite audit, the Auditor observed the DHS-prescribed sexual assault awareness notice in the intake processing area and in each hold room in English and Spanish only. In addition, during the onsite audit, the Auditor confirmed the facility did not have the DHS-prescribed SAA Information pamphlet readily available. IEPHR had obtained the pamphlet in the 15 most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the PREA information contained in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. During the onsite audit, the Auditor further observed the ICE National Detainee Handbook in the processing area, in both English and Spanish. In interviews with four DDOs it was indicated should a detainee speak a language other than English or Spanish they would access the facility computer to print the ICE National Detainee Handbook in the required language. The Auditor reviewed the facility computer and confirmed the facility has access to the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video recording of two LEP detainees being processed at the facility and confirmed neither detainee had been given any written material. Interviews with four DDOs, confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or had low vision, had limited reading skills, or an intellectual, psychiatric, or speech disability During the onsite audit, the Auditor confirmed the facility does not have access to written material, in-person, telephonic, or video interpretive services that would enable effective and accurate communication with detainees who may suffer from these types of disabilities. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or otherwise disabled the IEPHR would be notified prior to the detainee being transported to the holding room for processing and the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. To become compliant, the facility must institute a practice of providing the detainee who does not speak English or Spanish the PREA information in a manner they could understand. In addition, the facility must institute a practice of providing a detainee who is blind or have low vision, deaf or hard of hearing, or those who have intellectual, psychiatric, or speech disabilities access to the PREA information to include access to written material, in-person, telephonic, or video interpretive services. Once implemented, the facility must submit documentation that all staff have been trained on the new practice. The facility must provide the Auditor with the files of 10 detainees received during the Corrective Action Plan (CAP) period to include, if applicable, detainees who do not speak English or Spanish, who are blind or have low vision, deaf or hard of hearing, have intellectual, psychiatric, or speech disabilities, or have limited reading skills to confirm they are provided access to the PREA information in a manner they could understand.

§115.117 - Hiring and promotion decisions.

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

Notes:

(a)(b)(c)(d)(e)(f): 5 CFR 731, Executive Order 10450, ICE Directive 6-7.0, ICE Personnel Program Security and Suitability, and ICE Directive 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel, require "anyone entering or remaining in government serve undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." The policy outlines misconduct and criminal misconduct as grounds for unsuitability including material omissions or making false or misleading statements in the application. In addition, 5 CFR 731 requires investigations every five years. 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. Based on information provided in an email by the OPR Personnel Security (A) Division Chief, information on substantiated allegations of sexual abuse involving a former employee would be provided to prospective employers upon request, unless prohibited by law. The Auditor submitted 24 ICE employee names to the Personnel Security Unit (PSU) for verification of suitability and background checks prior to employment and every five years thereafter. All relevant information was provided and confirmed background checks are up to date for each employee name submitted. An interview with the PSA Compliance Manager, indicated if an employee had been involved in misconduct of this nature, the employee would not be employed by ICE. Interviews with four DDOs, indicated they are required to immediately report any misconduct related to sexual abuse to their supervisor. The facility does not enlist the services of contractors or volunteers who may have contact with detainees. During an informal interview with a staff member from the Mission Support Unit, the Auditor confirmed there have been no staff promotions during the audit period.

§115.118 - Upgrades to facilities and technologies.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): ICE Directive 11087.1 states, "When designing or developing any new ERO holding facility and in planning any substantial expansion or modification of existing holding facilities, the FOD, in coordination with the Office of Facilities Administration, Office of the Chief Financial Officer, shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to

protect detainees from sexual abuse and assault." According to the PAQ, and in interviews with the PSA Compliance Manager, it was indicated that IEPHR has not had any substantial expansion or modification during the audit period.

(b): ICE Directive 11087.1 states, "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a hold room, the FOD, in coordination with the Office of Facilities Administration, Office of the Chief Financial Officer, shall consider how such technology may enhance the agency's ability to protect detainees from sexual abuse and assault." During an interview with the PSA Compliance Manager, it was indicated the video monitoring equipment was upgraded in October 2022. The PSA Compliance Manager further indicated the camera locations were considered to enhance the Agency's ability to protect detainees from sexual abuse and assault, including but not limited to ensuring detainees could perform bodily functions without being viewed by staff of the opposite gender; however, a review of the submitted HFSAT confirmed the facility indicated no when asked "Has any new monitoring, electronic surveillance, or video equipment been installed in the past year that directly impacts the effectiveness or operations of the holing facility?" A review of the submitted HFSAT further confirmed the facility did not address the HFSAT's requirement to include information on how the Field Office considered the impact of this technology on protecting detainees from sexual abuse or assault.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. During an interview with the PSA Compliance Manager, it was indicated the video monitoring equipment was upgraded in October 2022. The PSA Compliance Manager further indicated the camera locations were considered to enhance the Agency's ability to protect detainees from sexual abuse and assault, including but not limited to ensuring detainees could perform bodily functions without being viewed by staff of the opposite gender; however, a review of the submitted HFSAT confirmed the facility indicated "no" when asked "Has any new monitoring, electronic surveillance, or video equipment been installed in the past year that directly impacts the effectiveness or operations of the holding facility?" A review of the submitted HFSAT further confirmed the facility did not address the HFSAT's requirement to include information on how the Field Office considered the impact of this technology on protecting detainees from sexual abuse or assault. To become compliant, the facility must submit documentation that confirms when upgrading the video monitoring system, the Field Office considered the impact of the technology on protecting detainees from sexual abuse or assault.

§115.121 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): ICE Directive 11062.2, states, "When feasible, secure and preserve the crime scene and safeguard information and evidence, consistent with ICE uniform evidence protocols and local evidence protocols in order to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." ICE Directive 11062.2 further states, "When outside agencies investigate sexual abuse or assault, cooperate with law enforcement agencies, OPR, and other outside investigators and endeavor to remain informed about the progress of the investigation, and ensure that detention facilities do the same." An interview with the PSA Compliance Manager indicated the facility does not investigate criminal or administrative allegations of sexual abuse in its holding facility. If a sexual abuse criminal in nature were to occur at IEPHR the facility would utilize the Fort Bliss Police Department (FBPD) Criminal Investigation Department (CID); however, if they refuse to investigate, the facility will notify the El Paso County Sheriff's Office (EPCSO). In addition, in an interview with the PSA Compliance Manager, it was indicated administrative investigations would be conducted by ICE OPR. IEPHR does not house juvenile detainees.

(b)(c)(d): ICE Directive 11087.1 states, "The FOD shall coordinate with ERO HQ and the ICE PSA Coordinator in utilizing, to the extent available and appropriated, community resources and services that provide expertise and support in the areas of crisis intervention and counseling to address victims' needs." In addition, ICE Directive 11087.1 states, "Where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the FOD shall arrange for or refer an alleged victim detainee to a medical facility to undergo a forensic medical examination, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel. If, in connection with an allegation of sexual abuse or assault, the detainee is transported for a forensic examination to an outside hospital that offers victim advocacy services, the detainee shall be permitted to use such services to the extent available, consistent with security needs." The Auditor reviewed a memorandum from the AFOD which indicates, "The IEPHR is a staging facility for administrative processing that typically detains individuals between two to three hours before moving them to a detention center; and therefore, the hold room utilizes the same memorandum of understanding (MOU) as the El Paso Processing Center." The facility provided the Auditor with a Letter of Understanding (LOU) between Tenet Hospitals d/b/a Providence Memorial Hospital, d/b/a Sierra Medical Center and the Division of Immigration Health Services (DIHS) which confirms the hospitals would provide emergency medical services to detainees, when needed; however, the Auditor reviewed the LOU and confirmed IEPHR is not included in the agreement. An interview with the PSA Compliance Manager, indicated if a sexual abuse were to occur and emergency medical services were needed, with consent, the detainee would be taken to Sierra Medical Center (SMC); however, the facility did not submit documentation to confirm SMC would provide a forensic exam including a SAFE/SANE or other medical professional at no cost to the detainee and only with the detainee's consent. The PSA Compliance Manager indicated the holding room does not have victim advocacy programs available due to the limited time that detainees are at the facility. There were no allegations of sexual abuse reported at IEPHR during the audit period.

Does Not Meet (b)(c)(d): The facility is not in compliance with subsections (b), (c) and (d) of the standard. The facility provided the Auditor with a "LOU between Tenet Hospitals d/b/a Providence Memorial Hospital, d/b/a Sierra Medical Center and DIHS which indicates the hospitals would provide emergency medical services to detainees, when needed"; however, the Auditor reviewed the LOU and confirmed IEPHR is not included in the agreement. An interview with the PSA Compliance Manager, indicated if a sexual abuse were to occur and emergency medical services were needed, with consent, the detainee would be taken to SMC; however, the facility did not submit documentation to confirm SMC would provide a forensic exam including a SAFE/SANE or other medical professional at no cost to the detainee and only with the detainee's consent. The PSA Compliance Manager indicated the holding room does not have victim advocacy programs available due to the limited time that detainees are at the facility. To become compliant the facility must identify a local hospital to provide the detainee victim a forensic exam, if evidentiarily or medically appropriate, by a SAFE/SANE Nurse or other qualified medical practitioner, at no cost to the detainee, and only with the detainee's consent. In addition, the facility must identify a community resource to provide expertise and support in the areas of crisis intervention and counseling and to provide advocacy services, if not available through the hospital agreement, to the detainee victim during a forensic exam and during the investigation process. The facility must provide documented training to all applicable staff regarding protocols developed and their responsibility to provide the detainee victim with all requirements of the standard. The facility must also provide the Auditor with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subparts (b), (c) and (d) of the standard.

(e): During an interview with the PSA Compliance Manager, it was indicated that IEPHR does not conduct criminal investigations and if a sexual abuse criminal in nature were to occur the facility would utilize the FBPD CID; however, if FBPD CID refuses to investigate, the facility would notify the EPCSO. IEPHR did not provide the Auditor with documentation to confirm IEPHR has made a request to the FBPD CID or the EPCSO to follow the requirements of paragraphs (a-d) of the standard.

Does Not Meet (e): IEPHR is not in compliance with subsection (e) of the standard. During an interview with the PSA Compliance Manager, he indicated that IEPHR does not conduct criminal investigations. If a sexual abuse criminal in nature were to occur, the facility would utilize FBPD CID; however, if FBPD CID refuses to investigate, the facility would notify the EPCSO. IEPHR did not provide the Auditor with documentation to confirm IEPHR has made a request to the FBPD CID or the EPCSO to follow the requirements of paragraphs (a-d) of the standard. To become compliant, IEPHR must request the FBPD CID and the EPCSO to follow the requirements of paragraphs (a-d) of the standard.

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

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

Notes:

(a)(b)(c)(d): ICE Directive 11062.2, states, "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." ICE Directive 11062.2 further states, "The JIC shall notify the DHS Office of Inspector General (OIG)" and "the OPR shall coordinate with the FOD or SAC and facility staff to ensure evidence is appropriately secured and preserved pending an investigation by federal, state, or local law enforcement, DHS OIG, or referral to OPR." In addition, ICE Directive 11062.2 states, "All sexual abuse and assault data collected pursuant to this Directive shall be maintained for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise." An interview with the PSA Compliance Manager indicated that IEPHR would follow the Agency protocols to ensure all allegations of sexual abuse are thoroughly investigated and reported to the Agency PSA Coordinator, JIC, DHS OIG, and the local law enforcement agency. In addition, in an interview with the PSA Compliance Manager, it was indicated administrative investigations would be conducted by ICE OPR. A review of the Agency website (www.ice.gov) confirmed the protocols are available to the public. There were no allegations of sexual abuse reported at IEPHR during the audit period.

(e): ICE Directive 11062.2 states, "The OPR shall coordinate with appropriate ICE entities and federal, state, or local law enforcement to facilitate necessary immigration processes that ensure availability of victims, witnesses, and alleged abusers for investigative interviews and administrative or criminal procedures, and provide federal, state, or local law enforcement with information about U nonimmigrant visa certification." On July 1, 2022, the Creative Corrections, LLC PM interviewed the Acting Section Chief of the OPR Directorate Oversight, and confirmed OPR Special Agents would provide the detainee victim of sexual abuse, which is criminal in nature, with timely access to U nonimmigrant status information. The OPR Acting Section Chief further stated that if an OPR investigation determined that a detainee was a victim of sexual abuse while in ICE custody, the assigned Special Agent would provide an affidavit documenting such in support of the detainees U nonimmigration visa application. There were no allegations of sexual abuse reported at the IEPHR during the audit period.

§115.131 – Employee, contractor, and volunteer training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): ICE Directive 11062.2 mandates, "All current employees required to take the training, as listed below, shall provide each employee with biennial refresher training to ensure that all employees know ICE's current sexual abuse policies and procedures, and all newly hired employees who may have contact with individuals in ICE custody shall also take the training within one year of their entrance on duty." ICE Directive 11062.2 further mandates, "All ICE personnel who may have contact with individuals in ICE Custody, including all ERO officers and HSI special agents shall receive training on, among other items: a) ICE's zero-tolerance policy for all forms of sexual abuse and assault; b) The right of detainees and staff to be free from sexual abuse or assault; c) Definitions and examples of prohibited and illegal behavior; d) Dynamics of sexual abuse and assault in confinement; e) Prohibitions on retaliation against individuals who report sexual abuse or assault; f) Recognition of physical, behavioral, and emotional signs of sexual abuse or assault, situations in which sexual abuse or assault may occur, and ways of preventing and responding to such occurrences, including: i) Common reactions of sexual abuse and assault victims; ii) How to detect and respond to signs of threatened and actual sexual abuse or assault; iii) Prevention, recognition, and appropriate response to allegations or suspicions of sexual abuse and assault involving detainees with mental or physical disabilities; and iv) How to communicate effectively and professionally with victims and individuals reporting sexual abuse or assault; g) How to avoid inappropriate relationships with detainees; h) Accommodating limited English proficient individuals and individuals with mental or physical disabilities; i) Communicating effectively and professionally with lesbian, gay, bisexual, transgender, intersex, or gender nonconforming individuals, and members of other vulnerable populations; j) Procedures for fulfilling notification and reporting requirements under this Directive; k) The investigation process; and l) The requirement to limit reporting of sexual abuse or assault to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes." The Auditor reviewed the ICE PREA Virtual University (VU) Training PowerPoint and confirmed that all elements required by the standards are included in the training material. The Auditor reviewed an IEPHR list of facility participants who attended a Teams meeting on November 30, 2022; however, no documentation was provided to confirm the purpose of the Teams meeting was to provide the required PREA training. In addition, no documentation was provided to indicate staff have received refresher training every two years. During an interview with the PSA Compliance Manager, and through Auditor observations, the IEPHR does not enlist the services of contractors or volunteers, who have contact with the detainees.

Does Not Meet (a)(b)(c): IEPHR is not in compliance with subsections (a), (b) and (c) of the standards. The Auditor reviewed an IEPHR list of facility participants who attended a Teams meeting on November 30, 2022; however, no documentation was provided to indicate the purpose of the Teams meeting was to provide the required PREA training. In addition, no documentation was provided to indicate staff have received refresher training every two years. To become compliant, IEPHR must provide documentation that confirms all ICE staff have received the refresher training required by subsection (a) of the standard.

§115.132 – Notification to detainees of the agency's zero-tolerance policy.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

ICE Directive 11062.2, mandates, "The FOD shall ensure that key information regarding ICE's zero-tolerance policy for sexual abuse and assault is visible or continuously and readily available to detainees (e.g., through posters, detainee handbooks, or other written formats)." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice posted in the intake processing area and in each of the holding cells. The posters included the name of the IEPHR PSA Compliance Manager; however, were English and Spanish only. In addition, the Auditor observed the ICE National Detainee Handbook in the processing area, available in both English and Spanish. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video recording of two detainees being processed at the facility and confirmed neither detainee had been given any written material. During the onsite audit, the Auditor further observed the facility did not have the DHS-prescribed SAA Information pamphlet readily available onsite or a process in place to ensure the information contained in the pamphlet is provided to the detainees. IEPHR had obtained the pamphlet in the 15 languages most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the written information included in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. Interviews with four DDOs, confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or had low vision, had limited reading skills or had an intellectual, psychiatric, or speech disability. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or had a similar disability the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. The Auditor reviewed the Agency website (www.ice.gov) and confirmed the Agency's zero-tolerance policy has been made available to the public. No detainees were present at the time of the on-site audit; and therefore, no detainee interviews were conducted.

Does Not Meet: The facility is not in compliance with the standard. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice posted in the intake processing area and in each of the holding cells. The posters included the name of the IEPHR PSA Compliance Manager; however, were in English and Spanish only. In addition, the Auditor observed the ICE National Detainee Handbook in the intake processing area, available in both English and Spanish only. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer, and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video recording of two detainees being processed at the facility and confirmed neither detainee had been given any written material. During the onsite audit, the Auditor confirmed the facility did not have the DHS-prescribed SAA Information pamphlet readily available onsite for distribution. IEPHR had obtained the pamphlet in the 15 most prevalent languages encountered by ICE: English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese prior to exiting the facility; however, prior to the Auditor exiting the facility IEPHR had not implemented a practice to ensure the detainee is provided the information contained in the DHS-prescribed SAA Information pamphlet in a manner he/she could understand. Interviews with four DDOs, confirmed they had difficulties articulating how communication would be established if the detainee was deaf or hard of hearing, blind or had low vision, had limited reading skills, or an intellectual, psychiatric, or speech disability. An interview with the PSA Compliance Manager indicated, if a detainee was deaf, blind, or had a similar disability the detainee would be transported to another ICE facility that is more equipped to handle detainees with disabilities; however, there is no documentation to confirm that IEPHR could not receive a detainee with a disability. To become compliant the facility must institute a practice that provides all detainees with key PREA information regarding the Agency's zero-tolerance policy, including detainees whose preferred language is other than English or Spanish, and are either developmentally or physically disabled. Once implemented, the facility must train all intake staff on the new practice and document the training. The facility must provide the Auditor with the files of 10 detainees received during the CAP period to include, if applicable, detainees who do not speak English or Spanish, who are blind or have low vision, deaf or hard of hearing, have intellectual, psychiatric, or speech disabilities, or have limited reading skills to confirm they are provided access to the PREA information in a manner they could understand.

§115.134 - Specialized training: Investigations.

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

Notes:

(a)(b): ICE Directive 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as Office of Detention Oversight staff, and other OPR staff, as appropriate. The training should cover, at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement setting, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process." An interview with the PSA Compliance Manager confirmed the facility does not investigate criminal or administrative allegations of sexual abuse in its holding facility. If a sexual abuse criminal in nature were to occur the facility would utilize the FBPD CID; however, if they refuse to investigate, the facility will notify the EPCSO. In addition, the PSA Compliance Manager stated, ICE OPR would conduct an administrative investigation. The Auditor reviewed the ICE OPR Investigating Incidents of Sexual Abuse and Assault PowerPoint and confirmed the training material includes interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement setting, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. In addition, the Auditor reviewed the ICE Staff Investigator training rosters, which indicated there are 87 trained investigators in the El Paso area, to include the IEPHR PSA Compliance Manager. There were no allegations of sexual abuse reported at IEPHC during the audit period.

§115.141 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(c)(d)(e): ICE Directive 11087.1 states, "The FOD should ensure that before placing detainees together in a hold room, there shall be consideration of whether a detainee may be at a high risk of being sexually abused or assaulted, and, when appropriate, shall take necessary steps to mitigate any such danger to the detainee." ICE Directive 11087.1 further states, "For detainees identified as being at high risk for victimization, the FOD shall provide heightened protection, including continuous direct sight and sound supervision, single-housing, or placement in a hold room actively monitored on video by a staff member sufficiently proximate to intervene, unless no such option is feasible. The FOD shall implement appropriate controls on the dissemination of any sensitive information regarding a detainee provided pursuant to screening procedures." In addition, ICE Directive 11087.1 states, "The FOD shall ensure that the following criteria are considered in assessing detainees for risk of sexual victimization, to the extent that the information is available: Whether the detainee has a mental, physical, or developmental disability; The age of the detainee; The physical build and appearance of the detainee; Whether the detainee has previously been incarcerated or detained; The nature of the detainee's criminal history; Whether the detainee has any convictions for sex offenses; Whether the detainee has self-identified as Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI) or gender nonconforming; Whether the detainee has self-identified as previously experiencing sexual victimization; and The detainee's own concerns about his or her physical safety." In interviews with 4 DDOs it was indicated detainees are not held over 12 hours at IEPHR however, should a detainee need to be held at the facility longer he/she would be transferred to the El Paso Processing Center for housing. In interviews with the PSA Compliance Manager and four DDOs, it was indicated a

detainee's risk is assessed by using the Risk Classification Assessment Worksheet (RCA). The Auditor reviewed the RCA worksheet and confirmed it includes the detainee's age, physical and mental disabilities, risk based on sexual orientation, gender identity, whether they are a victim of sex trafficking or have experienced past sexual abuse; however, the Auditor reviewed the submitted HFSAT which confirmed IEPHR only takes into consideration a detainee's gang affiliation, age, criminal history, gender, medical conditions, and physical stature to determine a detainee's risk of sexual victimization prior to placing him/her in a holding cell and not the entirety of information provided on the RCA. The Auditor observed the RCA on the facility computer system and verified that the information is properly controlled with user ids and passwords. During the on-site audit, the Auditor observed the processing area including the holding cells and confirmed each holding cell had a large observation window, allowing the officers to see the entire cell at all times; and therefore, if a detainee was a high risk for victimization, the facility would have continuous direct sight and sound of the detainee. In interviews with four random DDOs it was indicated if according to a detainee's risk assessment, or if the detainee had concerns about their safety, they would be placed in a holding cell by themselves. During the onsite audit, the Auditor reviewed a video recording of two detainees processed at IEPHR the previous day. The Auditor observed staff conducting the RCA with each detainee and that both detainees were at the facility for less than 30 minutes.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. In interviews with the PSA Compliance Manager and four DDOs, it was indicated a detainee's risk is assessed by using the Risk Classification Assessment Worksheet (RCA). The Auditor reviewed the RCA worksheet and confirmed it includes the detainee's age, physical and mental disabilities, risk based on sexual orientation, gender identity, whether they are a victim of sex trafficking or have experienced past sexual abuse; however the Auditor reviewed the submitted HFSAT which confirmed IEPHR only takes into consideration a detainee's gang affiliation, age, criminal history, gender, medical conditions, and physical stature to determine a detainee's risk of sexual victimization prior to placing him/her in a holding cell and not the entirety of information provided on the RCA. To become compliant the IEPHR must consider all information available to the facility on the RCA and not just a detainee's gang affiliation, age, criminal history, gender, medical conditions, and physical stature as indicated on the submitted HFSAT to determine a detainee's risk of sexual victimization prior to placing him/her in a holding cell. In addition, the facility must document that all DDOs are trained on the standard's requirement. The facility must submit to the Auditor 10 files of detainees who arrived during the CAP period to confirm all elements of the RCA are being considered in determining a detainee's risk of sexual victimization prior to placing him/her in a holding cell.

(b): Policy 11087.1 states, "The FOD shall ensure that detainees who may be held overnight with other detainees are assessed to determine their risk of being either sexually abused or sexually abusive, to include being asked about their concerns for their physical safety." According to the PAQ, the IEPHR does not house detainees overnight, and therefore, subsection (b) of the standard is not applicable.

§115.151 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): ICE Directive 11087.1 states, "a) The FOD shall ensure that detainees are provided instruction on how they can privately report incidents of sexual abuse or assault, retaliation of reporting sexual abuse or assault, or staff neglect or violations of responsibilities that may have contributed to such incidents to ERO personnel. b) The FOD shall implement procedures for ERO personnel to accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports." During the onsite audit, the Auditor observed the DHS-prescribed sexual abuse awareness notice posted in the intake processing area and in all holding cells in English and Spanish only. The signage provided information on how to make an anonymous call and how to contact the ICE ERO Detention Reporting and Information Line (DRIL) and the DHS OIG; however, there were no telephones available for a detainee to utilize the telephone numbers provided. When asked how a detainee would be able to call, a DDO reported the detainee would be allowed to utilize the telephone at the DDOs workstation; however, the DDO would remain in the area during the call. Interviews with the four DDOs indicated that the ICE National Detainee Handbook is available on-site in English and Spanish. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video of two detainees being process at IEPHR and confirmed neither detainee was provided with any written material. During the onsite audit the Auditor observed the facility did not have the DHS-prescribed SAA Information pamphlet readily available or a process in place to ensure the information contained in the pamphlet is provided to the detainees. Interviews with the PSA Compliance Manager and four DDO's indicated detainees are able to report an incident of sexual abuse, retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. The four DDOs were able to articulate they are required to accept and report allegations made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports.

Does Not Meet (a)(b): IEPHR is not in compliance of subsections (a) and (b) of the standard. During the onsite audit, the Auditor observed the DHS-prescribed sexual abuse awareness notice posted in the intake processing area and in all holding cells in English and Spanish only. The signage provided information on how to make an anonymous call and to contact the DRIL and the DHS OIG; however, there were no telephones available for the detainees to utilize the telephone numbers provided. When asked how a detainee would be able to complete a DDO reported the detainee would be allowed to utilize the telephone at the DDOs workstation; however,

the DDO would remain in the area during the call. Interviews with the four DDOs indicated that the ICE National Detainee Handbook is available on-site in English and Spanish. In interviews with four DDOs it was indicated that should a detainee speak a language other than English or Spanish they would access the necessary language, via the facility computer and it would be printed in the required language. The Auditor reviewed the facility computer and confirmed access to the ICE National Detainee Handbook in 14 of the most prevalent languages encountered by ICE: French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, Spanish and English; however, the Auditor reviewed a video of two detainees being process at IEPHR and confirmed neither detainee was provided with any written material. During the onsite audit, the Auditor observed the facility did not have the DHS-prescribed SAA Information pamphlet readily available or a process in place to ensure the information contained in the pamphlet is provided to the detainees. To become compliant, the facility must provide detainees with instructions on how to contact the DHS OIG or another designated office in a manner that all detainees can understand, to confidentially and, if desired, anonymously, report these incidents. In addition, the facility must provide telephone access that allows the detainee to make a report of sexual abuse confidentially and, if desired, anonymously. The facility must provide the Auditor with documentation that confirms the new practice has been implemented and all applicable staff have been trained on the new procedures.

§115.154 - Third-party reporting.

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

Notes:

ICE Directive 11087.1 states, "The FOD shall implement procedures for ERO personnel to accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness noticed posted in the intake processing area and all holding cells in English and Spanish. An interview with the PSA Compliance Manager indicated that third party reports can be made via the Agency website at http://www.ice.gov/PREA. A review of the website confirmed the Agency has made information available to the public on how to make a report on behalf of a detainee. The website provides the phone numbers for the DRIL, the DHS OIG, and ICE OPR; however, the Auditor found it difficult to navigate the website in order to locate the information. The Auditor utilized the "Report Crime" button, which is located on the ICE homepage; however, has not received a response.

Recommendation: The Auditor recommends the Agency ensures that when a third party makes an allegation of sexual abuse by utilizing the "Report Crime" function on the website a response is generated.

§115.161 - Staff reporting duties.

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

Notes:

(a)(b)(c): ICE Directive 11062.2 states, "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." ICE Directive 11062.2 further states, "Generalize training for all ICE staff include the requirement to limit reporting of sexual abuse or assault to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes." The facility provided a memorandum from Acting Deputy Director Lechleiter dated November 8, 2021. The memo reiterates the types of misconduct allegations that employees must report to the JIC, OPR, or the DHS OIG and those types of allegations that should be referred to local management. During interviews with four random DDOs it was indicated they could articulate their responsibility to report any knowledge, suspicion or information regarding a sexual abuse, 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, interviews with four DDOs indicated they could make a report of misconduct outside their chain of command to the DHS OIG.

(d): 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." An interview with the PSA Compliance Manager indicated if a detainee were a vulnerable adult, the detainee would be transported to another ICE facility that is more equipped to handle the detainee. A review of the HFSAT indicates the facility does not accept vulnerable adults or juvenile detainees.

§115.162 – Agency protection duties.

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

Notes:

ICE Directive 11062.2 state, "If an ICE employee has a reasonable belief that a detainee is subject of substantial risk of imminent sexual abuse or assault, he or she shall take immediate action to protect the detainee." Interviews with the PSA Compliance Manager and four DDOs confirmed their knowledge and understanding of the requirement to report to their immediate supervisor, separate the detainee from the threat, and place them under direct supervision.

§115.163 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d): ICE Directive 11062.2 mandates, "If the alleged assault occurred at a different facility from the one where it was reported, ensure that the administrator at the facility where the assault is alleged to have occurred is notified as soon as possible, but no later than 72 hours after receiving the allegation, and document such notification." The Auditor reviewed a memorandum which states, "If an allegation of this nature is received, the AFOD, or an individual acting in that capacity, would notify the head of that facility within 72 hours of the sexual abuse allegation and document the notification in writing." In an interview with the PSA Compliance Manager, it was indicated that he was aware of the responsibility to immediately notify the facility administrator within 72 hours where the allegation occurred and to document in writing the notification was made. The PSA Compliance manager further stated if he were to receive notification from another facility that an alleged sexual abuse had occurred within the IEPHR he would follow all reporting requirements and ensure that an investigation into the incident was conducted. There have been no notifications to the IEPHR from other facilities, or made from IEPHR to another facility, during the audit period.

§115.164 - Responder duties.

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

Notes:

(a)(b): ICE Directive 11087.1 states, "The FOD shall ensure that upon learning of an allegation that a detainee was sexually abused or assaulted, the responder, or his or her supervisor: a) separate the alleged victim and abuser; b) preserve and protects, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; c) 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; d) if the abuse occurred within a time period that still allows for the collection of physical evidence, ensures that the alleged abuser not to 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 an officer or agent, the responder shall request the alleged victim not to take any actions that could destroy physical evidence, and then notify an officer or agent." Interviews with the PSA Compliance Manager and four DDOs confirmed their knowledge of first responder duties. Each staff member could articulate they would call for back up, separate the victim and abuser, protect the crime scene, and request the victim not take any actions that could destroy evidence or allow the abuser to take any action that could destroy evidence. There are no non-security first responders at IEPHC. There were no allegations of sexual abuse reported at IEPHR during the reporting period.

§115.165 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): ICE Directive 11087.1 states, "The FOD shall ensure a coordinated, multidisciplinary team approach to responding to allegations of sexual abuse and assault occurring in holding facilities, or in the course of transit to or from holding facilities, as well as to allegation made by a detainee at a holding facility of sexual abuse or assault that occurred elsewhere in ICE custody." ICE Directive 11087.1 further states, "If a victim is transferred from a holding facility to a detention facility or to a non-ICE facility, the FOD shall inform the receiving facility of the indecent and the victim's potential need for medical or mental health care of victim services." A review of ICE Directive 11087.1 confirms it does not include "unless the victim requests otherwise." Interviews with four DDOs, confirmed their knowledge of first responder duties. Each DDO could articulate they would call for back up, separate the victim and abuser, protect the crime scene, and request the victim not take any actions that could destroy evidence or allow the abuser to take any action that could destroy evidence. In an interview, the PSA Compliance Manager confirmed if a detainee being transferred was a victim of sexual abuse, IEPHR staff would provide the receiving facility any information regarding the sexual abuse allegation, including the victim's need for any medical or social services follow-up and if the victim was transferred to a non-DHS facility, with the consent of the victim detainee, the same information would be provided to the receiving facility; however, the standard requires the detainee's consent should the detainee be transferred to a facility not covered by DHS PREA standards and not to non-DHS facilities. There were no allegations of sexual abuse reported at IEPHR during the reporting period.

Does Not Meet (c): ICE Directive 11087.1, as it relates to standard 115.165 is not consistent with the standard. The Directive as it relates to the coordinated response protocol does not include "unless the victim requests otherwise." Although Agency Directive, 11062.2 is compliant with the DHS PREA Standards, if hold rooms are using 11087.1 as their coordinated response protocol, or even a combination of both, then they would be deficient. In addition, in an interview with the PSA Compliance Manager it was confirmed if the victim was transferred to a non-DHS facility, with the consent of the victim detainee, the facility would provide the receiving any information regarding the sexual abuse allegation, including the victim's need for any medical or social services follow-up; however, the standard requires the detainee's consent should the detainee be transferred to a facility not covered by DHS PREA standards and not to non-DHS facilities. To become compliant, the Agency must update their written institutional plan to contain the required verbiage as written in 115.165 subpart (c). The facility must provide documented training of applicable staff on the updated written institutional plan to include the PSA Compliance Manager. If applicable, the facility must provide the Auditor with any investigation, medical, and detainee files regarding any detainee victim of sexual abuse transferred from BHR during the CAP period.

§115.166 - Protection of detainees from contact with alleged abusers.

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

Notes:

ICE Directive 11062.2 states, "The FOD shall ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring detainee contact pending the outcome of an investigation." An interview with the PSA Compliance Manager indicated that a staff member alleged to have perpetrated sexual abuse, or if the allegation was serious and the plausibility of the allegation make removal appropriate the staff member would be removed from his/her duties that include contact with detainees pending an outcome of an investigation. IEPHR does not have volunteers or contractors that have contact with detainees. There were no allegations of sexual abuse reported at IEPHR during the reporting period.

§115.167 - Agency protection against retaliation.

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

Notes:

ICE Directive 11062.2 states, "ICE employees shall not retaliate against any person, including the detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. However, ICE prohibits deliberately making false sexual abuse or assault allegations, as well as deliberately providing false information during an investigation, and such misconduct will be addressed through appropriate processes." An interview with the PSA Compliance Manager indicated staff are prohibited from retaliating against any person, including the detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The PSA Compliance Manager further indicated if a staff member was to engage in retaliation of another, they would be held accountable. Interviews with four DDOs confirmed their knowledge that retaliation of any kind is prohibited. There were no allegations of sexual abuse reported at IEPHR during the reporting period.

§115.171 - Criminal and administrative investigations.

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

Notes:

(a)(b)(c)(d)(e): ICE Directive 11062.2 states, "The FOD shall ensure that the facility complies with the investigation mandates established by PBNDS 2011, Standard 2.11, as well as other relevant detention standards and contractual requirements including by conducting a prompt, thorough, and objective investigation by qualified investigators." PBNDS 2011, Standard 2.11 states, "When outside agencies investigate sexual abuse or assault, cooperate with law enforcement agencies, OPR, and other outside investigators and endeavor to remain informed about the progress of the investigation, and ensure that detention facilities do the same." PBNDS 2011, Standard 2.11 further states, "The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." In addition, PBNDS 2011, Standard 2.11 states, "Administrative investigations procedures include preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviewing alleged victims, suspected perpetrators, and witnesses, reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator, assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph, an effort to determine whether actions or failures to act at the facility contributed to the abuse, documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings, and retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years and that such procedures shall govern the coordination and sequencing of administrative and criminal investigations, to ensure that the criminal investigation is not compromised by an internal administrative investigation." An interview with the PSA Compliance Manager confirmed that the facility does not investigate criminal or administrative allegations of sexual abuse in its holding facility. If a sexual abuse criminal in nature were to occur the facility would utilize the FBPD CID; however, if FBPD CID refuses to investigate, the facility would notify the EPCSO. The PSA Compliance Manager further indicated, he would cooperate with outside investigators and would remain informed on the investigation's progress. In addition, the PSA Compliance Manager indicated all administrative investigations would be conducted by ICE OPR. The Auditor reviewed the ICE OPR Investigating Incidents of Sexual Abuse and Assault PowerPoint and confirmed the training material includes interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement setting, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. In addition, the Auditor reviewed the ICE Staff Investigator training rosters, which confirmed there are 87 trained and qualified investigators in the El Paso area, to include the IEPHR PSA Compliance Manager. There were no allegations of sexual abuse reported at IEPHR during the audit period.

§115.172 - Evidentiary standard for administrative investigations.

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

Notes:

ICE Directive 11062.2 states, "The OPR will conduct either an OPR review or investigations, 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 or assault, and may not be terminated solely due to the departure of the alleged abuser or victim from the employment or control of ICE." An interview with the PSA Compliance Manager indicated administrative investigations are conducted

by ICE OPR. There were no allegations of sexual abuse reported at IEPHR during the audit period; therefore, compliance is based on Agency policy.

§115.176 - Disciplinary sanctions for staff.

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

Notes:

(a)(c)(d): ICE Directive 11062.2 states, "Upon receiving notification from a FOD or Special Agent in Charge (SAC) of the removal or resignation in lieu of removal of staff for violating agency or facility sexual abuse and assault policies; Report that information to appropriate law enforcement agencies, unless the activity was clearly not criminal; and make reasonable efforts to report that information to any relevant licensing bodies, to the extent known." An interview with the PSA Compliance Manager indicated staff are subject to disciplinary action, up to and including removal from their position and federal service for violations of the sexual abuse policies. There were no allegations of sexual abuse reported at IEPHR during the audit period.

§115.177 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b): ICE Directive 11062.2 states, "The FOD shall ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring detainee contact pending the outcome of an investigation." Interviews with the PSA Compliance Manager, four DDOs, and Auditor observations confirmed the IEPHR does not have contractors or volunteers that have contact with detainees.

§115.182 - Access to emergency medical services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): ICE Directive 11087.1 states, "The FOD shall ensure that detainee victims of sexual abuse or assault have timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The FOD shall coordinate with ERO HQ, and the Agency PSA Coordinator, in utilizing, to the extent available, any community resources and services that provide expertise and support in the areas of crisis intervention and counseling to address the victims' needs." ICE Directive 11087.1 further states, "Victims of sexual abuse shall be provided emergency medical and mental health services and any ongoing care necessary. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The Auditor reviewed a memorandum from the AFOD which indicates that the IEPHR is a staging facility for administrative processing that typically detains individuals between two to three hours before moving them to a detention center. The hold room utilizes the same memorandum of understanding as the El Paso Processing Center. The facility provided the Auditor with a "LOU between Tenet Hospitals d/b/a Providence Memorial Hospital and d/b/a Sierra Medical Center and DIHS which indicates the hospitals would provide emergency medical services to detainees, when needed"; however, the Auditor's review of the LOU confirmed, IEPHR is not included. An interview with the PSA Compliance Manager indicated if a sexual abuse were to occur and emergency medical services were needed, the detainee would be taken to SMC. The Auditor was not provided documentation to confirm that SMC would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and at no financial cost to the victim detainee regardless if the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, IEPHR has not provided documentation to confirm in the event of an incident of sexual abuse, the victim would be offered support services to include crisis intervention and counseling. There were no sexual abuse allegations reported at the IEPHR during the audit period.

Does Not Meet (a)(b): IEPHR is not in compliance with subsections (a) and (b) of the standard. The facility provided the Auditor with a LOU between Tenet Hospitals d/b/a Providence Memorial Hospital and d/b/a Sierra Medical Center and DIHS which indicates the hospitals would provide emergency medical services to detainees, when needed; however, the Auditor's review of the LOU confirmed IEPHR is not included. An interview with the PSA Compliance Manager, indicated if a sexual abuse were to occur and emergency medical services were needed, the detainee would be taken to SMC. The Auditor was not provided documentation to indicate that SMC would provide detainee victims of sexual abuse with emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care and at no financial cost to the victim detainee regardless of if the victim names the accuser or cooperates with any investigation arising out of an incident of sexual abuse. In addition, IEPHR has not provided documentation to confirm in the event of an incident of sexual abuse, the victim would be offered support services to include crisis intervention and counseling. To become compliant, IEPHR must coordinate with a community resource to provide expertise and support to include crisis intervention and counseling. In addition, the IEPHR must provide documentation that confirms SMC or another entity would provide detainee victims of sexual abuse timely, unimpeded access to emergency medical treatment, including emergency contraceptives and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care and at no financial cost to the victim detainee regardless if the victim names the abuser or cooperates with an investigation arising out of an incident of sexual abuse. IEPHR must provide documented training to all applicable staff regarding their responsibility to provide the detainee victim with all requirements of the standard. If applicable, IEPHR must provide the Auditor with any investigative files where the detainee victim was transported to an outside hospital following an incident of sexual abuse to confirm compliance with subsections (a) and (b) of the standard.

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

(a): ICE Directive 11087.1 states, "The FOD shall conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault occurring at a holding facility and, unless the allegation was determined to be unfounded, prepare a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and assault. Such review shall ordinarily occur within 30 days of ERO's receipt of the investigation results from the investigating authority." The Auditor reviewed the Sexual Abuse or Assault Incident Review form. The form indicates that an incident review team must complete the review within 30 days of the conclusion of any law enforcement or administrative investigation with a finding of substantiated or unsubstantiated. An interview with the PSA Compliance Manager indicated a review would be completed within 30 days after receiving the finding from law enforcement. The PSA Compliance Manager further indicated a written report would be completed by the review team which would include a need for a change in policy or practice that would improve the facility's efforts to prevent, detect, or respond to sexual abuse. In addition, the PSA Compliance Manager indicated the report and any corrective action implemented would be forwarded to the Agency PSA Coordinator. There were no allegations of sexual abuse reported at IEPHC during the audit period.

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

(a): ICE Directive 11062.2 states, "Data collected pursuant to this Directive shall be securely retained in accordance with agency record retention policies and the agency protocol regarding investigation of allegations, (see PBNDS 2011, section 2.11 page 142). All sexual abuse and assault data collected pursuant to this Directive shall be maintained for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise," and, "investigative files would be retained at the OPR Headquarters in the Agency's online case management system (JICMS)." An interview with the PSA Compliance Manager confirmed if a sexual abuse were to occur at IEPHR, the investigative file would be maintained by ICE OPR. There were no allegations of sexual abuse reported at IEPHR during the audit period.

§115.193 – Audits of standards.
Outcome: Not Low Risk
Notes:

The PREA Audit at the IEPHR was the second audit for this facility. After a careful review, it was determined that the facility is not in compliance with 11 of the standards; therefore, not in compliance with the DHS PREA Standards. IEPHR only holds detainees up to 12 hours, and there has not been an allegation of sexual abuse between June 14, 2018, through April 12,2023; however, the Auditor must take into consideration the areas of non-compliance which include both policy and procedural issues. Therefore, the Auditor has determined that the facility is not low risk.

§115.201 - Scope of audits.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(d)(e)(i)(j): During all stages of the audit, including the on-site audit, the Auditor was able to review available policies, memos, and other documentation required to make an assessment on PREA compliance. There were no detainees present at the facility during the on-site audit for the Auditor to interview. The Auditor observed the notification of the audit posted throughout the hold room in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. No detainee, outside entity, or staff correspondence was received prior to the on-site audit, during the on-site audit, or post-audit.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	18
Number of standards not met:	11
Number of standards N/A:	1
Number of standard outcomes not selected (out of 31):	0
Facility Risk Level:	Not Low Risk

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 5/26/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 5/19/2023

Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 5/29/2023

Program Manager's Signature & Date