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

Homeland Security

| 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:** | Washington Field Office | | |
| **Field Office Director:** | Russell Hott | | |
| **ERO PREA Field Coordinator:** | (b) (6), (b) (7)(C) | | |
| **Field Office HQ physical address:** | 4797 Murdock Street Chantilly, VA 20151 | | |
| **Mailing address:** *(if different from above)* | Same as above | | |
| **INFORMATION ABOUT THE FACILITY BEING AUDITED** | | | |
| **Basic Information About the Facility** | | | |
| **Name of facility:** | Immigration Centers of America-Farmville | | |
| **Physical address:** | 508 Waterworks Road, Farmville, VA 23901-2674 | | |
| **Mailing address:** *(if different from above)* | Same as above | | |
| **Telephone number:** | 434-395-8131 | | |
| **Facility type:** | DIGSA | | |
| **Facility Leadership** | | | |
| **Name of Officer in Charge:** | (b) (6), (b) (7)(C) | **Title:** | Director of Detention |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | 434-395-(b) (6), (b) |
| **Facility PSA Compliance Manager** | | | |
| **Name of PSA Compliance Manager:** | (b) (6), (b) (7)(C) | **Title:** | PSA Compliance Manager |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | 434-395-(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 Immigration Centers of America-Farmville (ICAF) met 28 standards, had 1 standard 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 November 9, 2024, and ended on May 7, 2024. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Not Met: 11

- §115.32 - Other Training
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.62 - Protection Duties
- §115.65 - Coordinated Response
- §115.66 - Protection of detainees from contact with alleged abusers
- §115.67 - Agency protection against retaliation
- §115.82 - Access to emergency medical and mental health services
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review

The facility submitted documentation, through the Agency, for the CAP on November 9, 2023, through April 30, 2024. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on May 7, 2024. In a review of the submitted documentation, to demonstrate compliance with the deficient standards, the Auditor determined compliance with 100% of the deficient 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. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable.

**§115. 32 - Other training**

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

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "Training on FDC's Sexual Abuse and Assault Prevention and Intervention Program will be included in basic training for all employees, volunteers, and contract personnel and will also be included in annual refresher training. When educating volunteers and other contractors who have contact with detainees, FDC shall ensure these individuals have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed how to report such incidents. In this paragraph "other contractor" means a person who provides services on a non-recurring basis to the facility pursuant to a contractual agreement with the facility. The Training Manager will maintain written documentation verifying employee, volunteer, and contractor training." The Auditor reviewed the facility Volunteer Orientation Training curriculum and confirmed the curriculum includes indicators of sexual assault and that an incident of sexual abuse must be reported; however, a review of the Volunteer Orientation Training curriculum could not confirm the training curriculum notifies volunteers and "other" contractors of the Agency and facility zero-tolerance policies or how to report an incident of sexual abuse. The Auditor reviewed the files of one volunteer and one "other" contractor and confirmed both had received Volunteer Orientation Training; however, the training is not compliant with subsection (b) of the standard. In an interview with the PSA Compliance Manager it was confirmed "other" contractors, as described in subsection (d) of the standard who provide services on a non-recurring basis to the facility pursuant to a contractual agreement with the Agency or facility are escorted by staff; and therefore, have not been trained on their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures.

**Does Not Meet (a)(b):** The facility is not in compliance with subsections (a) and (b) of the standard. The Auditor reviewed the facility Volunteer Orientation Training curriculum and confirmed the curriculum includes indicators of sexual assault and that an incident of sexual abuse must be reported; however, a review of the Volunteer Orientation Training curriculum could not confirm the training curriculum notifies volunteers and "other" contractors of the Agency and facility zero-tolerance policies or how to report an incident of sexual abuse. The Auditor reviewed the files of one volunteer and one "other" contractor and confirmed both had received Volunteer Orientation Training; however, the training is not compliant with subsection (b) of the standard. In an interview with the PSA Compliance Manager it was confirmed "other" contractors, as described in subsection (d) of the standard who provide services on a non-recurring basis to the facility pursuant to a contractual agreement with the Agency or facility are escorted by staff; and therefore, have not been trained on their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures. To become compliant the facility must update the Volunteer Orientation Training to include the standard's requirements to notify volunteers and "other" contractors of the Agency and facility zero-tolerance policies and how to report an incident of sexual abuse. In addition, the facility must provide documentation that confirms all volunteers and "other contractors" as described in subsection (d) of the standard, regardless of whether or not they are escorted by staff, have been trained on the updated curriculum.

**Corrective Action Taken (a)(b):** The facility submitted a revised Volunteer Orientation training curriculum. The Auditor reviewed the revised training curriculum and confirmed the revised training curriculum notifies all volunteers and other contractors who have contact with detainees of both the Agency and FDC zero-tolerance policies regarding sexual abuse and how to report an allegation of sexual abuse. The facility submitted the Volunteer and Other Contractor Training and Acknowledgment form which includes the Agency and FDC zero tolerance policies towards all forms of sexual abuse or assault and sexual harassment. In addition, the facility provided the Auditor a copy of the back of a visitor badge which confirmed the badges include verbiage which notifies wearers of the Agency and FDC zero-tolerance policies regarding sexual abuse and how to report an incident of sexual abuse. The facility submitted 23 samples of the Volunteer and Other Contractor Training and Acknowledgement forms which confirmed volunteers and "other contractors" are receiving training to include both the Agency and FDC zero-tolerance policies regarding sexual abuse and how to report an allegation of sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

**§115. 35 - Specialized training: Medical and mental health care**
**Outcome:** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
**Notes:**

(b)(c): ICAF policy ICAF-DO-06 states, "While some victims can be clearly identified, many, or even most, may not come forward directly with information. Some victims may be identified through unexplained injuries, changes in physical behavior due to injuries, abrupt personality changes such as withdrawal or suicidal behavior, or other changes in behavior. In accordance with DHS PREA standard 115.35, medical and mental health care staff will receive specialized training, subject to the review and approval of the Field Office Director or other designated ICE Official, on the following components of FDC's Sexual Abuse and Assault Prevention and Intervention program: a) Procedures for examining victims of sexual abuse. b) Procedures for treating victims of sexual abuse. c) How to detect, assess, and respond to signs of sexual abuse and sexual harassment effectively and professionally. d) How and to whom to report allegations or suspicions of sexual abuse. e) How to preserve physical evidence of sexual abuse." An interview with the HSA indicated all medical and mental health staff are required to attend specialized training and complete general PREA training as required by §115.31. The HSA provided the Auditor a certificate which confirmed she has received training in Rape/Sexual Assault; however, a training curriculum was not provided. The Auditor reviewed a computerized print-out confirming each medical and mental health staff had completed Sexual Abuse and Assault Prevention (SAAPI/PREA/LGBTI) training; however, a review of exhibits provided by the facility and two medical staff training files could not confirm medical and mental health staff have completed specialized training to include procedures for examining victims of sexual abuse; procedures for treating victims of sexual abuse; how to detect, assess, and respond to signs of sexual abuse and sexual harassment effectively and professionally; how and to whom to report allegations or suspicions of sexual abuse; and how to preserve physical evidence of sexual abuse. A review of a memorandum to the file and interviews with the facility Director and SDDO confirmed ICAF policy ICAF-DO-06 has been reviewed and approved by the Agency.

**Does Not Meet (b):** The facility is not in compliance with subsection (b) of the standard. The HSA provided the Auditor a certificate indicating that she had received training in Rape/Sexual Assault; however, a training curriculum was not provided. The Auditor reviewed a computerized print-out confirming each medical and mental health staff had completed Sexual Abuse and Assault Prevention (SAAPI/PREA/LGBTI) training; however, a review of exhibits provided by the facility and two medical staff training files could not confirm medical and mental health staff have completed specialized training as required by subsection (b) of the standard. To become compliant, the facility must provide the Auditor with a specialized training curriculum which includes the required elements of subsection (b) of the standard. In addition, the facility must provide documentation that confirms all medical and mental health staff have received the required training.

**Corrective Action Taken (b):** The facility submitted the Farmville Detention Center: Sexual Assault and Abuse Prevention and Intervention Program Sozo HealthCare specialized training curriculum. The Auditor reviewed the Farmville Detention Center: Sexual Assault and Abuse Prevention and Intervention Program Sozo HealthCare specialized training curriculum and confirmed the training curriculum includes (1) How to detect and assess signs of sexual abuse; (2) How to respond effectively and professionally to victims of sexual abuse, (3) How and to whom to report allegations or suspicions of sexual abuse, and (4) How to preserve physical evidence of sexual abuse. In addition, the facility provided the previous training curriculum from Armor Correctional Health Services, Inc. The Auditor reviewed the submitted Armor Correctional Health Services, Inc. training curriculum and confirmed the training curriculum includes all elements required by subsection (b) of the standard; and therefore, the Auditor no longer requires documentation to confirm all medical staff and mental health staff employed at FSA during the on-site audit have received specialized training as required by subsection (b) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (b) of the standard.

**§115. 41 - Assessment for risk of victimization and abusiveness**
**Outcome:** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
**Notes:**

(a)(b)(g): ICAF policy ICAF-DO-06 states, "Detainees will be screened, classified, and initially housed by staff within 12 hours of arrival at the facility. The purpose of this screening is to identify those likely to be sexual aggressors or sexual victims and detainees will be housed accordingly to prevent sexual abuse or assault. Detainees who are considered likely to become victims will be placed in the least restrictive housing that is available and appropriate." ICAF policy ICAF-DO-06 further states, "In accordance with the SOPs on Admission and Release and Custody Classification System: each new arrival will be kept separate from the general population until he or she is classified and may be housed accordingly. Detainees who have been identified as being at risk for sexual victimization shall be immediately referred to a qualified Mental Health professional for further assessment, treatment and/or counseling." In addition, ICAF policy ICAF-DO-06 states, "Responses to questions and material collected on ICA Form 74 are considered sensitive information and therefore staff have an obligation to keep this data confidential. Staff shall only disseminate information captured on ICA Form 74 on a need-to-know basis to prevent the exploitation of material to a detainee's detriment by staff or other detainees." An interview with

the PSA Compliance Manager indicated the "PREA Assessment Tool for Risk of Victimization and Abusiveness" is completed upon intake. An interview with the PSA Compliance Manager further indicated detainees do not receive their initial housing assignment until the completion of the initial risk assessment which is completed within 12 hours as required by subsection (b) of the standard. In addition, the PSA Compliance Manager indicated detainees are kept separate from detainees housed in general population until initially housed following the completion of the risk assessment. The PSA Compliance Manager further indicated the facility Offender Management System (OMS) is designed to track the detainee who has been identified as being vulnerable to sexual abuse by placing a V Code into the system or a P Code to track detainees identified to be sexual aggressors. In interviews with the PSA Compliance Manager, it was further indicated access to answers provided to questions on the initial risk assessment, and PREA codes are limited to the PSA Compliance Manager, facility Investigators, and the Intake Processing staff; however, the PSA Compliance Manager could not articulate the procedure to follow to ensure a detainee identified as being vulnerable to sexual abuse and a detainee identified as being a sexual aggressor would be housed separately. In addition, during an interview with the Intake Processing Supervisor, it was confirmed she could not articulate how the information gained from the initial risk assessment is used to determine initial housing including how the OMS codes used to identify the detainee vulnerable to sexual abuse or sexual aggression could or would affect the initial housing assignment of the detainee. The Auditor reviewed 20 detainee files and confirmed an initial risk assessment had been completed for each detainee; however, 2 of the reviewed files confirmed the initial risk assessment had been completed 2 days after the initial intake date; 2 of the files confirmed the assessment had been completed the day before the detainee's arrival to the facility, and 1 file did not include the date the initial risk assessment had been completed; and therefore, a review of the files could not confirm the initial risk assessment was completed in accordance with subsections (a) and (b) of the standard even though the detainees had been given an initial housing assignment which included co-mingling with general population detainees.

**Does Not Meet (a)(b):** The facility is not in compliance with subsections (a) and (b) of the standard. During interviews the PSA Compliance Manager could not articulate the procedure to follow to ensure a detainee identified as being vulnerable to sexual abuse and a detainee identified as being a sexual aggressor would be housed separately. In addition, during an interview with the Intake Processing Supervisor, it was confirmed she could not articulate how the information gained from the initial risk assessment is used to determine initial housing including how the OMS codes used to identify the detainee vulnerable to sexual abuse or sexual aggression could or would affect the initial housing assignment of the detainee. The Auditor reviewed 20 detainee files and confirmed an initial risk assessment had been completed for each detainee; however, 2 of the reviewed files confirmed the initial risk assessment had been completed 2 days after the initial intake date; 2 of the files confirmed the assessment had been completed the day before the detainee's arrival to the facility, and 1 file did not include the date the initial risk assessment had been completed; and therefore, a review of the files could not confirm the initial risk assessment was completed in accordance with subsections (a) and (b) of the standard even though the detainees had been given an initial housing assignment which included co-mingling with general population detainees. In addition, the Auditor reviewed one sexual abuse investigation file and confirmed the detainee was not reassessed following an incident of sexual abuse or victimization. To become compliant the facility must submit documentation that confirms all applicable staff, to include Intake, Classification, and the PSA Compliance Manager have been trained on the standard's requirement to complete an initial assessment and classification of all detainees within 12 hours of arrival ensuring detainees who are identified as being vulnerable to sexual abuse or sexual aggression are housed to prevent sexual abuse. In addition, the facility must submit documentation that confirms all applicable staff, to include Intake, Classification, and the PSA Compliance Manager received training on the standard's requirement to ensure steps are taken to mitigate dangers of sexual abuse including keeping new arrivals separate from general population until the detainee has completed an initial assessment and is initially classified. The facility must provide the Auditor 10 detainee files to confirm initial housing and classification is completed as required by subsections (a) and (b) of the standard to include the use of the OMS to track detainees likely to be vulnerable to sexual abuse or sexual aggression to determine initial housing.

**Corrective Action Taken (a)(b):** The facility submitted Corrective Action Training Slides. The Auditor reviewed the slides and confirmed the slides included all subsections required by §115.41. In addition, the facility provided a training which confirmed all applicable staff, to include Intake, Classification, and the PSA Compliance Manager, have been trained on the requirements of the standard. The facility submitted a revised PREA Assessment Tool for Risk of Victimization and Abusiveness. The Auditor reviewed the revised PREA Assessment Tool and confirmed "The Housing Detainee" section was revised to include "Any detainee identified as a KNOWN VICTIM DESIGNATION or KNOWN SEXUAL AGRESSOR DESIGNATION requires the APPROVAL and SIGNATURE of the Shift Commander or Higher Authority authorizing a detainee's housing assignment" and "prior to authorizing this detainee's housing assignment, I acknowledge that I have reviewed the information contained in the above assessment along with indication captured in FDC's Offender Management System to ensure all steps were taken to prevent sexual abuse and mitigate any such dangers." The Auditor reviewed the revised PREA Assessment Tool and further confirmed revised PREA Assessment Tool requires the Shift Commander's signature and housing assignment based on the results of the assessment. The facility provided training rosters to confirm shift commanders and supervisors have been trained on the revised assessment and their responsibilities of utilizing the

assessment to determine housing of the victim detainee or potential abuser. The facility submitted 10 detainee files seven of which included detainees who identified during the initial risk assessment as being at risk for sexual abuse or sexual aggression. The Auditor reviewed the files and confirmed the files included an initial risk assessment, the OMS designation for tracking purposes, housing assignment, and signature of the Shift Commander for those identified at risk for victimization or at risk for abusiveness. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

(e): ICAF policy ICAF-DO-06 states, "FDC shall reassess each detainee's risk of victimization or abusiveness between 60 to 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." Interviews with the Intake Processing Supervisor and PSA Compliance Manager indicated that a reassessment is conducted with all detainees between 60-90 days of the initial risk assessment utilizing the "PREA Assessment Tool for Risk of Victimization and Abusiveness". The PSA Compliance Manager further indicated a reassessment is completed if warranted based on the receipt of new information or following an incident of sexual abuse. The Auditor reviewed 20 detainee files and confirmed 2 detainees had been housed at the facility over 60 days and a reassessment had been completed as required by subsection (e) of the standard. The facility provided the Auditor, an assessment that had been completed after the detainee had reported an incident of sexual abuse which had occurred while housed at another facility.

**Does Not Meet (e):** The facility is not in compliance with subsection (e) of the standard. The Auditor reviewed one sexual abuse investigation file and confirmed the detainee was not reassessed following an incident of sexual abuse or victimization. To become compliant, the facility must submit documentation that confirms all applicable staff, including facility investigators have been trained on the standard's requirement to reassess all detainees following an incident of sexual abuse or sexual victimization. In addition, if applicable, the facility must submit any sexual abuse allegation investigation files and the corresponding reassessment that occur during the corrective action plan (CAP) period.

**Corrective Action Taken (e):** The facility submitted Corrective Action Training Slides. The Auditor reviewed the slides and confirmed the slides included all subsections required by §115.41. In addition, the facility provided a training roster which confirmed all applicable staff, to include facility Investigators, have been trained on the requirements of the standard. The facility submitted two investigative files which confirmed the detainee victims had been reassessed based on a report of sexual abuse. The Auditor reviewed the two submitted sexual abuse allegation investigation files with corresponding reassessments and confirmed reassessments were completed as required by subsection (e) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (e) of the standard.

**§115. 42 - Use of assessment information**

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

**Notes:**

(a): ICAF policy ICAF-DO-06 states, "FDC shall use the information from ICA Form 74 for the purpose of determining and making an informed assignment of detainees to housing, recreation and other activities, and voluntary work. Individualized determinations shall be made on a case-by-case basis to ensure the safety of each detainee." An interview with the PSA Compliance Manager indicated the "PREA Assessment Tool for Risk of Victimization and Abusiveness" is completed upon intake. The PSA Compliance Manager further indicated information from the initial risk assessment is added to the OMS which is designed to track the detainee who has been identified as being vulnerable to sexual abuse by placing a V Code into the system or a P Code to track detainees identified to be sexual aggressors. However, during interviews the PSA Compliance Manager and the Intake Processing Supervisor it was confirmed neither staff could articulate how the facility would utilize the information learned from the initial assessment to inform assignment of detainees to initial housing. The Auditor reviewed a "Volunteer Work Program Agreement", which states, "In accordance with the DHS PREA Standard §115.42 a review of the detainees risk assessment for victimization was conducted. This review concluded that the detainee is cleared to participate in the voluntary work program." The Auditor reviewed 20 detainee files and confirmed an assessment had been completed for each detainee; however, 2 of the files indicated the assessment had been completed two days after the detainee arrived at the facility and 1 detainee file did not include the date the initial risk assessment had been completed; and therefore, the Auditor could not confirm the information gathered from the initial risk assessment was utilized in determining assignment of initial housing. A review of 20 detainee files could not confirm the utilization of the OMS system and Volunteer Work Program Agreement as none of the files included detainees who were assigned to a voluntary work program.

**Does Not Meet (a):** The facility is not in compliance with subsection (a) of the standard. In an interview with the PSA Compliance Manager, it was indicated information from the initial risk assessment is added to the OMS which is designed to track the detainee who has been identified as being vulnerable to sexual abuse by placing a V Code into the system or a P Code to track detainees identified to be sexual aggressors. However, during interviews with the PSA Compliance Manager and the Intake Processing Supervisor it was confirmed neither staff could articulate how the facility would utilize the

information learned from the initial assessment to inform assignment of detainees to initial housing. The Auditor reviewed 20 detainee files and confirmed an assessment had been completed for each detainee; however, 2 of the files indicated the assessment had been completed two days after the detainee arrived at the facility and 1 detainee file did not include the date of the initial risk assessment; and therefore, the Auditor could not confirm the information gathered from the initial risk assessment was utilized in determining assignment of initial housing. To become compliant the facility must submit documentation that confirms all applicable staff, to include Intake, Classification, and the PSA Compliance Manager have been trained on the standard's requirement to utilize the information gained from the initial risk assessment to inform assignment to initial housing. In addition, the facility must submit 10 detainee files to confirm the facility utilized the information gained from the initial risk assessment to inform assignment to initial housing.

**Corrective Action Taken (a):** The facility submitted Corrective Action Training Slides. The Auditor reviewed the Corrective Action Training slides and confirmed the slides included the standard's requirement to utilize the information gained from the initial risk assessment to inform assignment to initial housing. The facility provided training rosters to confirm all applicable staff, to include Intake, Classification, and the PSA Compliance Manager, have been trained on the standard's requirement. The facility submitted a revised PREA Assessment Tool for Risk of Victimization and Abusiveness. The Auditor reviewed the revised PREA Assessment Tool and confirmed "The Housing Detainee" section was revised to include "Any detainee identified as a KNOWN VICTIM DESIGNATION or KNOWN SEXUAL AGRESSOR DESIGNATION requires the APPROVAL and SIGNATURE of the Shift Commander or Higher Authority authorizing a detainee's housing assignment" and "prior to authorizing this detainee's housing assignment, I acknowledge that I have reviewed the information contained in the above assessment along with indication captured in FDC's Offender Management System to ensure all steps were taken to prevent sexual abuse and mitigate any such dangers." The Auditor reviewed the revised PREA Assessment Tool and further confirmed revised PREA Assessment Tool requires the Shift Commander's signature and housing assignment based on the results of the assessment. The facility provided training rosters to confirm shift commanders and supervisors have been trained on the revised assessment and their responsibilities of utilizing the assessment to determine housing of the victim detainee or potential abuser. The facility submitted 10 detainee files seven of which included detainees who identified during the initial risk assessment as being at risk for sexual abuse or sexual aggression. The Auditor reviewed the files and confirmed the files included an initial risk assessment, the OMS designation for tracking purposes, housing assignment, and signature of the Shift Commander for those identified at risk for victimization or at risk for abusiveness. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

**§115. 62 - Protection duties**
**Outcome:** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
**Notes:**

ICAF policy ICAF-DO-06 states, "If a FDC staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." Interviews with the facility Director, the PSA Compliance Manager, and six security line staff confirmed if they become aware a detainee is at substantial risk of sexual abuse their first response would be to take immediate action to protect the detainee. The Auditor reviewed one sexual abuse allegation investigation file which included contract staff-on-detainee and confirmed, although ICE accepted the allegation, the facility initially did not consider the allegation a PREA; and therefore, did not take action immediate action to protect the detainee.

**Does Not Meet:** The facility does not meet the standard. The Auditor reviewed one sexual abuse allegation investigation file which included contract staff-on-detainee and confirmed, although ICE accepted the allegation, the facility initially did not consider the allegation a PREA; and therefore, did not take immediate action to protect the detainee. To become compliant the facility must train all security line staff and the PSA Compliance Manager on the standard's requirement to take immediate action to protect the detainee from a risk of sexual abuse. In addition, if applicable the facility must submit all sexual abuse allegation investigation files that occur during the CAP period.

**Corrective Action Taken:** The facility submitted Corrective Action Training Slides. The Auditor reviewed the slides and confirmed the slides included the standard's requirement to take immediate action to protect the detainee from a risk of sexual abuse. The facility provided training rosters to confirm all security line staff and the PSA Compliance Manager have been trained on the standard's requirement to take immediate action to protect the detainee from risk of sexual abuse. The facility submitted two investigative files. The Auditor reviewed the two submitted sexual abuse allegation investigation files and confirmed immediate action had been taken to protect the detainee from risk of sexual abuse; and therefore, accepts the submitted files to confirm compliance with standard 115.62 and no longer requires the facility submit all sexual abuse allegation investigation files that occurred during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in compliance with standard 115.62.

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

(c)(d): ICAF policy ICAF-DO-06 states, "If a detainee victim of sexual abuse is transferred between DHS immigration detention facilities, FDC shall, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the incident and the detainee victim's potential need for medical or social services. If a detainee victim is transferred from FDC to a non-DHS facility, the facility, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. If the receiving facility is unknown to FDC, the Director of Detention shall notify the Field Office Director, so that he or she can notify the receiving facility." Interviews with the facility Director and the HSA indicated that the facility would provide information regarding the victim's potential need for medical and mental health services. If the detainee is transferred to a non-DHS facility, the medical staff would obtain the detainee's consent prior to providing the information to the receiving facility.

**Does Not Meet (c)(d):** The facility is not in compliance with subsections (c) and (d) of the standard. The Auditor reviewed ICAF policy ICAF-DO-06 which serves as the facility coordinated response plan and confirmed the coordinated response plan requires "if a detainee victim of sexual abuse is transferred between DHS immigration detention facilities, FDC shall, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the incident and the detainee victim's potential need for medical or social services. If a detainee victim is transferred from FDC to a non-DHS facility, the facility, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." However, the standard requires the facility response plan includes the verbiage, "If a victim of sexual abuse is transferred between facilities, covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." To become compliant, the facility shall revise ICAF-DO-06 to include "If a victim of sexual abuse is transferred between facilities, covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "If a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." Once ICAF policy ICAF-DO-06 is updated facility must provide documentation that confirms all applicable staff, including medical, have been trained on the updated policy. In addition, if applicable the facility must provide the Auditor with any detainee sexual abuse allegation investigation files, and the corresponding medical records, of any detainee transferred to a facility not covered by paragraph (c) of this section that occurred during the CAP period.

**Corrective Action Taken (c)(d):** The facility submitted revised ICAF policy ICAF-DO-06 which states, "If a victim of sexual abuse is transferred between facilities, covered by subpart A or B of this part of the DHS PREA standards, the sending facility, FDC, shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "If a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section of the DHS PREA standards, the sending facility, FDC, shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The facility submitted Corrective Action Training Slides. The Auditor reviewed the slides and confirmed the slides included the standard's requirements "if a victim of sexual abuse is transferred between facilities, covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The facility submitted training rosters to confirm all applicable staff, including medical, have been trained on the requirements of subsections (c) and (d) of the standard. The facility submitted a memorandum to Auditor which confirmed ICAF did not have an allegation of sexual abuse in which the detainee victim had been transferred to a facility not covered by paragraph (c)n during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (c) and (d) of the standard.

**§115. 66 - Protection of detainees from contact with alleged abusers**
**Outcome:** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
**Notes:**

ICAF policy ICAF-DO-06 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. FDC shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions of facility policies." Interviews with the facility Director and the PSA Compliance Manager indicated that if a staff member, contractor, or volunteer is alleged to have been involved in an incident of sexual abuse the staff member, contractor, or volunteer would be removed from any position having detainee contact until the conclusion of the investigation. The Auditor reviewed one investigative file and could not confirm the staff member involved in the allegation had been removed from detainee contact until the completion of the investigation.

**Does Not Meet:** The facility is not in compliance with the standard. The Auditor reviewed one investigative file and could not confirm the staff member involved in the allegation had been removed from detainee contact until the completion of the investigation. To become compliant, the facility must submit documentation that confirms all applicable staff, including the PSA Compliance Manager has received training on the standard's requirement to remove staff, contractors, and volunteers suspected of perpetrating sexual abuse from all duties requiring detainee contact pending the outcome of an investigation. In addition, if applicable, the facility must provide any sexual abuse allegation investigation files that include staff, contractor or volunteers that have occurred during the CAP period.

**Corrective Action Taken:** The facility submitted Corrective Action Training slides. The Auditor reviewed the slides and confirmed the slides included the standard's requirement to remove staff, contractors, and volunteers suspected of perpetrating sexual abuse from all duties requiring detainee contact pending the outcome of an investigation. The facility submitted training rosters to confirm all staff, to include the facility PSA Compliance Manager, were currently being trained on the standard requirements. As the facility was in the process of training all facility staff the Auditor accepts the on-going training for compliance. The facility submitted two investigative files occurring during the CAP period which included staff-on-detainee. The Auditor reviewed both sexual abuse allegation files and confirmed the alleged staff perpetrators were advised they were being removed from all detainee contact pending the outcome of the investigation. Upon review of all submitted documentation the Auditor now finds the facility in compliance with standard 115.66.

**§115. 67 - Agency protection against retaliation**
**Outcome:** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "Monitor to ensure that any staff, contractor, or volunteer does not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. a) For at least 90 days following a report of sexual abuse, FDC shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. This procedure for monitoring applies to criminal investigations conducted by the Farmville Police Department and facility conducted administrative investigations. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. b) The PSA Compliance Manager, Facility Chaplains, and Mental Health staff are the primary individuals assigned to conduct monitoring for retaliation and shall document compliance with this provision of the DHS PREA Standards. When monitoring for retaliation, FDC shall employ multiple protection measures, such as housing changes, removal of allege d staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigation. Emotional support services for detainees and staff are contingent on individuals consenting to such services. Additional monitoring also includes periodic interviews with detainees or staff, reviewing detainee disciplinary reports, program changes, or negative performance reviews or reassignment of staff." In an interview with the PSA Compliance Manager, it was indicated he and the facility Chaplain are responsible for retaliation monitoring of detainee victims of sexual abuse and HR staff is responsible to staff. The PSA Compliance Manager further indicated a detainee victim of sexual abuse would be monitored for retaliation for up to 90 days and the review would include reviewing the detainee's housing, disciplinary record, or any program changes, that may have occurred as a result of retaliation. An interview with the HRM indicated staff who report or cooperate with an allegation of sexual abuse investigation would be monitored for retaliation to include negative performance reviews or reassignment of the staff member's assigned post. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the facility had not monitored the victim detainee for retaliation.

**Does Not Meet (c):** The Agency and facility are not in compliance with subsection (c) of the standard. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the Agency and the facility had not conducted

retaliation monitoring of the detainee victim. To become compliant, the facility must submit documentation that confirms all applicable staff, including the PSA Compliance Manager, has received training on the standard's requirement to monitor for at least 90 days following an incident of sexual abuse monitor to ensure any staff, contractor, or volunteer does not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. In addition, if applicable, the facility must provide any sexual abuse allegation investigation files, and the corresponding monitoring documentation, that has occurred during the CAP period.

**Corrective Action Taken (c):** The facility submitted Corrective Action training slides. The Auditor reviewed the slides and confirmed the slides included the standard's requirement to monitor for at least 90 days following an incident of sexual abuse monitor to ensure any staff, contractor, or volunteer does not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The facility submitted training rosters to confirm all applicable staff, including the PSA Compliance Manager, have been trained on the standard's requirement to monitor for at least 90 days following an incident of sexual abuse monitor to ensure any staff, contractor, or volunteer does not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The facility submitted one sexual abuse allegation investigation file which occurred during the CAP period. The Auditor reviewed the sexual abuse allegation investigation file and the corresponding monitoring and confirmed the facility had begun to monitor the detainee victim for signs of retaliation. A review of the sexual abuse allegation investigation file further confirmed the detainee victim was monitored until he was transferred from ICAF, and the monitoring included the facility reviewing disciplinary reports, classification changes, and housing assignments. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

**§115. 82 - Access to emergency medical and mental health services**
**Outcome:** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
**Notes:**

(a)(b): ICAF policy ICAF-DO-06 states, "Detainee victims of sexual abuse shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted prophylaxis, in accordance with professionally accepted standards of care. Treatment services, including any emergency medical treatment services, shall be provided to detainee victims without financial cost and regardless of whether the detainee victim names the abuser or cooperates with any investigation arising out of the incident." An interview with the HSA indicated a detainee victim of sexual abuse would be triaged at ICAF and then transported to Lynchburg General Hospital for emergency medical treatment including a SANE exam. A victim would be offered emergency contraceptives and sexually transmitted infections prophylaxis. During the on-site audit, the Auditor spoke with a victim advocate from the YMCA and confirmed SANE exams are conducted at the Lynchburg General Hospital and a YWCA advocate would accompany a victim detainee to the hospital and stay with him during the SANE exam to provide emotional support and crisis intervention. In addition, in an interview with a victim advocate from the YWCA it was further confirmed emergency services would be provided to detainee victims of sexual abuse to sexually transmitted infections prophylaxis, without financial cost, and whether the victim names the abuser or cooperates with an investigation. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the detainee victim had not been provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required by the standard. The facility does not house female detainees.

**Does Not Meet (a):** The facility is not compliant with section (a) of the standard. The Auditor reviewed one investigative file and confirmed the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. To become compliant the facility must develop a protocol that requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. In addition, the facility must submit documentation that confirms staff have been trained on the implemented protocol. In addition, if applicable, the facility must submit all sexual abuse allegation investigation files and the corresponding medical and mental health records that occur during the CAP period.

**Corrective Action Taken (a):** The facility submitted Corrective Action Training Slides. The Auditor reviewed the slides and confirmed the slides included an updated protocol to include an updated PREA/SAAPI Response Timeline and Checklist. The facility provided training rosters which confirmed applicable staff have been trained on the protocols. The facility submitted the updated PREA/SAAPI Response Timeline and Checklist. The Auditor reviewed the updated PREA/SAAPI Response Timeline and Checklist and confirmed the checklist includes the time the detainee victim is escorted to Medical, name of the staff member who escorted the detainee victim to medical, and the time the detainee is informed of available victim support services. A review of the updated PREA/SAAPI Response Timeline and Checklist further confirmed the detainee is given the DHS-prescribed SAA Information pamphlet and the YWCA Brochure. The facility submitted two sexual

abuse allegation investigation files and corresponding medical and mental health records which occurred during the CAP period. The Auditor reviewed the submitted sexual abuse allegation investigation files and confirmed both detainee victims had been offered medical and emotional support services and counseling; and therefore, the Auditor no longer requires the facility to submit all sexual abuse allegation investigation files and the corresponding medical and mental health records which occur during the CAP period. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

**§115. 83 - Ongoing medical and mental health care for sexual abuse victims and abusers**
**Outcome:** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
**Notes:**

(a)(b)(c)(d)(e)(f)(g): ICAF policy ICAF-DO-06 states, "FDC in cooperation with Sozo Medical shall offer medical and mental health evaluation services and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention" ICAF policy ICAF-DO-06 further states, "The evaluation and treatment of such victims shall include, as appropriate, follow-up services, crisis intervention, treatment plans, and, when necessary, referrals for continued care following a detainee victim transfer to, or placement in, other facilities, or release from custody." In addition, ICAF policy ICAF-DO-06 states "The medical and mental health services provided to detainee victims of sexual abuse and assault shall be consistent with the services and care offered at the community level." ICAF policy ICAF-DO-06 further states, "In the event FDC houses female detainees, victims of sexually abusive vaginal penetration by a male abuser shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the detainee victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections and HIV testing as medically appropriate. Medical staff shall arrange for appropriate medications and provide routine examination follow-up when necessary. Treatment services, including any emergency medical treatment services, shall be provided to detainee victims without financial cost and regardless of whether the detainee victim names the abuser or cooperates with any investigation arising out of the incident. FDC in cooperation with Sozo Medical shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." In an interview with the HSA, indicated, detainee victims of sexual abuse are provided medical and mental health services, free of charge consistent, if not better, than the level of care they would receive in the community. An interview with the HSA further indicated the facility would attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days and offer treatment. An interview with an advocate from the YWCA indicated all detainee victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate, and all services are offered free of charge regardless of if the victim detainee names the abuser or cooperates with the investigation. An interview with a mental health LPC indicated a detainee perpetrator of sexual abuse would receive an evaluation immediately upon learning of a history of sexual abuse and a treatment would be established if the abuser is willing to participate in treatment. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the detainee was eventually provided with information on how to contact the YWCA; however, the detainee was not taken to medical for evaluation as required by subsection (a) of the standard.

**Does Not Meet (a):** The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed one sexual abuse investigation file and confirmed the detainee was eventually provided with information on how to contact the YWCA: however, the detainee was not taken to medical for evaluation as required by subsection (a) of the standard. To become compliant the facility must train all supervisory staff in the requirement to deliver all alleged victims of sexual abuse to the medical department for evaluation and treatment as appropriate. In addition, if applicable, the facility must submit any sexual abuse allegation investigation files and the corresponding medical and mental health records that occur during the CAP period.

**Corrective Action Taken (a):** The facility submitted Corrective Action Training Slides. The Auditor reviewed the slides and confirmed the slides include the standard's requirement to deliver all alleged victims of sexual abuse to the medical department for evaluation and treatment as appropriate. The facility submitted training rosters which all supervisory staff were trained in the standard's requirement to deliver all alleged victims of sexual abuse to the medical department for evaluation and treatment as appropriate. The facility submitted two sexual abuse allegation investigation files and the corresponding medical and mental health records which occurred during CAP period. The Auditor reviewed the submitted sexual abuse allegation investigation files and the corresponding medical and mental health records and confirmed both detainee victims had been taken to the medical department for evaluation and treatment as needed. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

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

(a)(b)(c): ICAF policy ICAF-DO-06 states, "Conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. Staff assigned to the sexual abuse incident review committee shall implement recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the Field Office Director, for transmission to the ICE PSA Coordinator. Additionally, the review committee shall consider: Whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. Whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation." An interview with the PSA Compliance Manager indicated the facility would complete an incident review within 30 days of the conclusion of the investigation which considers if the allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, and whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation. The PSA Compliance Manager further indicated during the reporting period, the facility has not had an allegation of sexual abuse that would require an incident review. The Auditor reviewed the PREA allegation spreadsheet which indicated, an incident review had been conducted on the one sexual abuse allegation investigation reported during the audit period as required by subsection (a) of the standard; however, the facility did not provide documentation to confirm a written report was prepared at the conclusion of the investigation. Therefore, the Auditor could not confirm the incident review considered whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; or whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation. In addition, as no report was submitted to the Auditor the Auditor could not confirm the review and response had been submitted to the Agency PSA Coordinator. The Auditor reviewed the facility 2022 annual review negative report, and an email from the facility Director confirming the report had been forwarded to the AFOD; however, the Auditor could not confirm the report had been forwarded to the Agency PSA Coordinator.

**Does Not Meet (a)(b)(c):** The facility is not in compliance with subsections (a), (b) and (c) of the standard. The PSA Compliance Manager further indicated during the reporting period; the facility has not had an allegation of sexual abuse that would require an incident review. The Auditor reviewed the PREA allegation spreadsheet which indicated, an incident review had been conducted on the one sexual abuse allegation investigation reported during the audit period as required by subsection (a) of the standard; however, the facility did not provide documentation to confirm a written report was prepared at the conclusion of the investigation. Therefore, the Auditor could not confirm the incident review considered whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; or whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation. In addition, as no report was submitted to the Auditor, the Auditor could not confirm the review and response had been submitted to the Agency PSA Coordinator. The Auditor reviewed the facility 2022 annual review negative report, and an email from the facility Director, confirming the report had been forwarded to the AFOD; however, the Auditor could not confirm the report had been forwarded to the Agency PSA Coordinator. To become compliant, the facility must provide the Auditor with documentation that all staff responsible for conducing incident reviews are trained on the requirements of subsections (a) and (b) of the standard. If applicable, the facility must submit all sexual abuse allegation investigation files and the corresponding incident reviews that occur during the CAP period. In addition, the facility must submit documentation to confirm the 2022 annual negative report has been forwarded to the Agency PSA Coordinator.

**Corrective Action Taken (a)(b)(c):** The facility submitted Corrective Action Training Slides. The Auditor reviewed the slides and confirmed the slides included the requirements of subsections (a) and (b) of the standard. The facility submitted training rosters to confirm all staff responsible for conducting incident reviews are trained on the requirements of subsections (a) and (b) of the standard. The facility submitted the 2022 Annual Review of Sexual Abuse Investigations and Resulting Incident Reviews for 2022 Negative Report and an email to confirm the report had been forwarded to the Agency PSA Coordinator in accordance with subsection (c) of the standard. The facility submitted a sexual abuse allegation investigation file which occurred during the CAP period. The Auditor reviewed the file and confirmed the facility had completed a Sexual Abuse Incident Review within 30 days of the unsubstantiated finding. A review of the file further confirmed the review included whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or

otherwise caused by other group dynamics at the facility; or whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation. In addition, the facility submitted email documentation to confirm the review and response had been forwarded to the Agency PSA Coordinator. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

**AUDITOR CERTIFICATION:**

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

*Robin Bruck* May 20, 2024
**Auditor's Signature & Date**

(b) (6), (b) (7)(C) May 20, 2024
**Assistant Program Manager's Signature & Date**

(b) (6), (b) (7)(C) May 20, 2024
**Program Manager's Signature & Date**

# PREA Audit: Subpart A
# DHS Immigration Detention Facilities
# Audit Report

Homeland Security

| AUDIT DATES | | | |
|---|---|---|---|
| **From:** | 9/19/2023 | **To:** | 9/21/2023 |
| **AUDITOR INFORMATION** | | | |
| **Name of auditor:** | Robin Bruck | **Organization:** | Creative Corrections, LLC |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone #:** | (409) 866- |
| **PROGRAM MANAGER INFORMATION** | | | |
| **Name of PM:** | (b) (6), (b) (7)(C) | **Organization:** | Creative Corrections, LLC |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone #:** | (409) 866 - |
| **AGENCY INFORMATION** | | | |
| **Name of agency:** | U.S. Immigration and Customs Enforcement (ICE) | | |
| **FIELD OFFICE INFORMATION** | | | |
| **Name of Field Office:** | Washington | | |
| **Field Office Director:** | Russell Hott | | |
| **ERO PREA Field Coordinator:** | (b) (6), (b) (7)(C) | | |
| **Field Office HQ physical address:** | 14797 Murdock Street, Chantilly, VA 20151 | | |
| **INFORMATION ABOUT THE FACILITY BEING AUDITED** | | | |
| **Basic Information About the Facility** | | | |
| **Name of facility:** | Immigration Centers Of America Farmville | | |
| **Physical address:** | 508 Waterworks Road, Farmville, Virginia 23901 | | |
| **Telephone number:** | | | |
| **Facility type:** | Dedicated Inter-governmental Service Agreement | | |
| **PREA Incorporation Date:** | 4/17/2015 | | |
| **Facility Leadership** | | | |
| **Name of Officer in Charge:** | (b) (6), (b) (7)(C) | **Title:** | Director |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone #:** | (434) 395- |
| **Name of PSA Compliance Manager:** | (b) (6), (b) (7)(C) | **Title:** | PSA Compliance Manager |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone #:** | (434) 395- |

## 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 U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Immigration Centers of America-Farmville (ICAF) was conducted between September 19-21, 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 the U.S. Immigration and Custom 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 to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR) External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. ICAF is privately owned by Immigration Centers of America (ICA) and operates under contract with the DHS ICE Office of Enforcement and Removal Operations (ERO). ICAF is in Farmville, Virginia. This is the third DHS PREA audit for ICAF and includes a review period between January 15, 2021, and September 21, 2023.

Approximately 30 days prior to the on-site audit, the ERAU Inspections and Compliance Specialist (ICS) Team Lead (TL), (b) (6), (b) (7)(C) provided the Auditor with the facility Pre-Audit Questionnaire (PAQ), Agency policies, facility policies, and other supporting documentation through the ICE SharePoint. The PAQ, policies, and supporting documentation had been organized utilizing the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into folders for ease of auditing. Prior to the on-site audit, the Auditor reviewed all documentation provided, the Agency website, and the facility website. The main policy that governs ICAF's sexual abuse prevention, intervention and response efforts is ICAF policy ICAF-DO-06 Sexual Abuse and Assault Prevention and Intervention.

An entrance briefing was held in the ICAF conference room on Tuesday, September 19, 2023, at 8:15 a.m. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) TL, ICS, ICE/OPR/ERAU
Robin M. Bruck, Certified DOJ/DHS PREA Auditor, Creative Corrections, LLC
(b) (6), (b) (7)(C) ICE/OPR/Program Inspection and Auditing Division
(b) (6), (b) (7)(C) Assistant Director, ICE/OPR/ICE Inspections
(b) (6), (b) (7)(C) ICE Contractor, Acuity, ICE/OPR
(b) (6), (b) (7)(C) Director, ICA
(b) (6), (b) (7)(C) Quality Assurance, ICA
(b) (6), (b) (7)(C), PSA Compliance Manager, ICA
(b) (6), (b) (7)(C) Detention and Deportation Officer (DDO), ICE/OPR/ERO
(b) (6), (b) (7)(C) DDO, ICE/OPR/ERO

The Auditor introduced herself and provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained the audit process is designed to not only assess compliance through written policy and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on a review of the policies and procedures, observations made during the facility on-site visit, documentation review, and conducting interviews with staff and detainees.

An on-site audit tour of the facility was conducted by the Auditor and key staff from ICAF, ICE ERAU, and ICE OPR. All areas of the facility where detainees are afforded the opportunity to go were observed including housing units, program areas, booking/intake, recreation, visitation, laundry, food service, library, and

medical. In addition, the Auditor observed the control center, sally port, and administrative offices. During the on-site audit, the Auditor made visual observations of bathrooms, shower areas, camera locations, and the adequacy of staffing levels in all areas of the facility. There were no notable blind spots in the facility. The Auditor observed, in English and Spanish, the DHS-prescribed sexual assault awareness notice, the ICE Detention and Reporting Information Line (DRIL) poster, DHS Office of Inspector General (OIG) poster, the Young Women's Christian Association (YWCA) poster, and information for contacting the consular officials in the housing units and all common areas of the facility. In addition, the Auditor tested the numbers provided for the DRIL, DHS OIG, YWCA, and the facility PREA Hotline and confirmed all were in good working order.

ICAF utilizes (b) (7)(E) to assist with monitoring the detainees. During the on-site audit, the Auditor observed video cameras present in all areas, to include but not limited to, (b) (7)(E) (b) (7)(E). Video cameras are monitored 24/7 and can pan, tilt, and zoom (PTZ). Cameras are monitored by officers assigned to the (b) (7)(E) and have the capability to retain video for up to one year. The Auditor reviewed the camera views from the (b) (7)(E) and confirmed no (b) (7)(E) or detainees in the state of undress could be viewed by cross-gender staff responsible for monitoring detainees utilizing the camera system.

ICAF houses adult male detainees who are awaiting deportation or have criminal charges pending in the State of Virginia. The facility PAQ indicated the top four nationalities housed at the facility are El Salvador, Honduras, Guatemala, and Mexico. The facility PAQ further indicated ICAF's design capacity is 528; however, on the first day of the on-site audit there were 287 detainees housed at ICAF. The detainee average length of stay at the facility is 60 days. Detainees are housed in dorm settings within nine housing units. In addition, there are 13 beds in the medical unit and 11 cells in the Administrative Segregation (AS) unit which includes 4 cells dedicated to detainees placed into Protective Custody (PC). There were no detainees housed in medical, AS, or PC during the on-site audit. The Auditor conducted 20 randomly selected detainee interviews, which included 19 Limited English Proficient (LEP) detainees, utilizing the services of Language Services Associates (LSA) provided by Creative Corrections, LLC, and 1 detainee victim who reported an incident of sexual abuse. All interviews were conducted in a private setting allowing for confidentiality for those participating in the interview process. ICAF does not house female detainees, juvenile detainees, or family detainees.

A review of the ICAF PAQ indicates the facility has 150 staff who have recurring contact with detainees, which includes 112 security staff (63 males and 49 females). In addition, to security staff, the remaining staff consists of administration, maintenance, and religious services. Medical and mental health services are provided to detainees through SozoHealthcare, LLC. Food services are provided through Trinity Services Group and commissary services are provided through Keefe Commissary Network. In addition, the facility utilizes the services of religious volunteers; however, there were no active volunteers providing services during the on-site audit. Security staff work in two shifts 0600-1800 and 1800-0600. The facility provided the Auditor with staff rosters for staff interviews and file reviews. The Auditor conducted a total of 20 staff interviews, utilizing 16 interview protocols, which included random security line staff (6), facility Director, Supervisory Detention and Deportation Officer (SDDO), PSA Compliance Manager/Investigator, Human Resource Manager (HRM), Health Service Administrator (HSA), Licensed Professional Counselor (LPC), Contractor (1), staff member who Supervise Detainees in Segregation (1), Retaliation Monitor (1), SART Team member (1), Grievance Officer (GO), Intake Processing Supervisor/Classification staff (1), custody first responder (1), and non-custody first responder (1). All interviews were conducted in a private setting, allowing for confidentiality for those participating in the interview process.

The facility PAQ reported there are four specially trained Investigators to complete all allegations of sexual abuse. A review of the facility "PREA Allegation Spreadsheet" confirmed the facility had one allegation of

sexual abuse investigation that had been closed during the reporting period. The Auditor reviewed the sexual abuse allegation investigation file and confirmed the allegation involved contract staff-on-detainee and had been determined to be unsubstantiated.

An exit briefing was conducted on Thursday, September 21, 2023, at 3:30 p.m. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C), TL, ICS, ICE/OPR/ERAU
Robin M. Bruck, Certified DOJ/DHS PREA Auditor, Creative Corrections, LLC
(b) (6), (b) (7)(C), Director, ICA
(b) (6), (b) (7)(C), Quality Assurance, ICA
(b) (6), (b) (7)(C), PSA Compliance Manager, ICA
(b) (6), (b) (7)(C), DDO, ICE/OPR/ERO
(b) (6), (b) (7)(C) Health Services Administrator (HSA), Sozo Healthcare, LLC
(b) (6), (b) (7)(C) Assistant Field Office Director (AFOD), ICE/OPR/ERO (via telephone)
(b) (6), (b) (7)(C) Deputy of Programs, ICA

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

## SUMMARY OF AUDIT FINDINGS

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

**Number of Standards Exceeded: 1**

- §115.33 - Detainee Education

**Number of Standards Met: 28**

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
- §115.13 - Detainee supervision and monitoring
- §115.15 - Limits to cross-gender viewing and searches
- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
- §115.17 - Hiring and promotion decisions
- §115.18 - Upgrades to facilities and technologies
- §115.21 - Evidence protocols and forensic medical examinations
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight
- §115.31 - Staff Training
- §115.34 - Specialized training: Investigations
- §115.43 - Protective Custody
- §115.51 - Detainee Reporting
- §115.52 - Grievances
- §115.53 - Detainee access to outside confidential support services
- §115.54 - Third-party reporting
- §115.61 - Staff and Agency Reporting Duties
- §115.63 - Reporting to other Confinement Facilities
- §115.64 - Responder Duties
- §115.68 - Post-allegation protective custody
- §115.71 - Criminal and administrative investigations
- §115.72 - Evidentiary standard for administrative investigations
- §115.73 - Reporting to detainees
- §115.76 - Disciplinary sanctions for staff
- §115.77 - Corrective action for contractors and volunteers
- §115.78 - Disciplinary sanctions for detainees
- §115.81 - Medical and mental health screening; history of sexual abuse
- §115.87 - Data collection
- §115.201 - Scope of Audit

**Number of Standards Not Met: 11**

- §115.32 - Other Training
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.62 - Protection Duties
- §115.65 - Coordinated Response
- §115.66 - Protection of detainees from contact with alleged abusers

- §115.67 - Agency protection against retaliation
- §115.82 - Access to emergency medical and mental health services
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review

**Number of Standards Not Applicable: 1**

- §115.14 - Juvenile and family detainees

## PROVISIONS

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

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

**Outcome:** Meets Standard

**Notes:**

(c): ICAF policy ICAF-DO-06 states, "Farmville Detention Center will articulate and adhere to a standard of zero tolerance for incidents involving all forms of sexual abuse or assault that may occur in the facility. Sexual assault or abuse of detainees by other detainees, staff, volunteers, or contract personnel is prohibited and subject to administrative, disciplinary, and criminal sanctions." The Auditor reviewed ICAF policy ICAF-DO-06 and confirmed ICAF policy ICAF-DO-06 includes definitions of sexual abuse and general PREA definitions. In addition, ICAF policy ICAF-DO-06 outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment through; but not limited to, hiring practices, training, unannounced rounds, mandatory reporting, investigations, and support, and crisis intervention from victim advocates. During the on-site audit, the Auditor observed the DHS-prescribed sexual abuse and assault awareness notice posted in English and Spanish on all housing units. Formal interviews with six security line staff confirmed they were knowledgeable regarding the Agency's and the facility's zero-tolerance policy. A review of a memorandum to the file and interviews with the facility Director and SDDO confirmed ICAF policy ICAF-DO-06 has been reviewed and approved by the Agency.

(d): ICAF policy ICAF-DO-06 states, "The Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager) is designated as the Sexual Abuse and Assault Prevention and Intervention Program Coordinator." An interview with the PSA Compliance Manager confirmed he was extremely knowledgeable of the DHS PREA standards. An interview with the PSA Compliance Manager further confirmed he is the point of contact for the Agency PSA Coordinator and has sufficient time and authority to oversee the facility's efforts to comply with the facility sexual abuse prevention and intervention policies and procedures. During the on-site audit, the Auditor reviewed the facility organizational chart which confirmed the PSA Compliance Manager has sufficient authority to oversee the facility's efforts to comply with the facility sexual abuse prevention and intervention policies and procedures.

**Corrective Action:**

No corrective action needed.

**§115.13 - Detainee supervision and monitoring**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "FDC shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. FDC shall develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and shall review those guidelines at least annually. The Director of Detention and PSA Compliance Manager will be involved in this annual review of supervision and monitoring guidelines. In determining adequate levels of detainee supervision and determining the need for video monitoring, FDC shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, 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." A review of the ICAF PAQ indicates the facility employs 112 security staff, with duty hours from 0600-1800 and 1800-0600 consisting of 63 males and 49 females who may have reoccurring contact with detainees. In addition, to security staff, the remaining staff consists of administration, maintenance, and religious services. Medical and mental health services are provided to detainees through SozoHealthcare, LLC. Food services are provided through Trinity Services Group and commissary services are provided through Keefe Commissary Network. In addition, the facility utilized the services of religious volunteers; however, there were no active volunteers providing services during the on-site audit. The PAQ further indicates there are (b) (7)(E) [redacted], located throughout the facility. During an interview with the facility Director, it was indicated the facility is contractually obligated to maintain levels of sufficient facility staffing. An interview with the PSA Compliance Manager indicated ICAF staffing levels and the need for video monitoring are reviewed annually considering all elements required by subsection (c) of the standard. The Auditor reviewed the facility's "Annual Review of Farmville Detention Center Detainee Supervision Guidelines" report, dated June 5, 2023, and confirmed the facility considers generally accepted detention and correctional practices; judicial findings of inadequacy; the physical layout of the facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the outcome and recommendations of sexual abuse incident review reports; and other relevant factors to include the length of time the detainees spend at ICAF when determining adequate staffing levels and the need for video monitoring. During the on-site audit, Auditor observations confirmed the facility had sufficient supervision to protect detainees from sexual abuse. The Auditor reviewed the comprehensive detainee supervision guidelines and confirmed an annual review had been conducted in accordance with subsection (b) of the standard.

(d): ICAF policy ICAF-DO-06 states, "FDC's PSA Compliance Manager, Shift Commanders and Assistant Shift Commanders, and other supervisory staff designated by the Director will conduct frequent unannounced security inspections of the facility with specific emphasis on detainee housing units for the purpose of identifying and deterring sexual abuse of detainees. These inspections will occur during night as well as day shifts. Designated supervisory staff will maintain the confidentiality of these security inspections to prevent alerting others that these checks are occurring. Unannounced security inspections will be recorded in the facility blotter." An interview with the PSA Compliance Manager indicated unannounced security inspections are completed by supervisory staff daily on each shift. The PSA Compliance Manager further indicated unannounced security inspections are documented in the "facility blotter", which is a computer program maintained by staff assigned to the control center. During the on-site audit, the Auditor observed the "facility blotter" and confirmed unannounced security inspections are conducted daily on each shift at random times.

**Corrective Action:**

No corrective action needed.

**§115.14 - Juvenile and family detainees**

**Outcome:** Not Applicable

**Notes:**

(a)(b)(c)(d): The Auditor reviewed a memorandum to the file which states, "The current contract Immigration Centers of America-Farmville has with Immigration Customs and Enforcement stipulates the Farmville Detention Center will only house adult male detainees over the age of 18. The Farmville Detention Center does not detain juvenile and family detainees." Interviews with the facility Director, PSA Compliance Manager, and the Auditor's direct observations, confirmed the facility does not house juvenile detainees or family units; and therefore standard 115.14 is not applicable.

**Corrective Action:**

No corrective action needed.

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

**Outcome:** Meets Standard

**Notes:**

(b)(c)(d): ICAF policy ICAF-DO-06 states, "Cross-gender pat searches are strictly prohibited, and Detention Officers are only authorized to conduct pat searches of detainees that are of the same gender as the staff member. Although FDC policy strictly prohibits cross-gender pat searches, the facility shall adhere to the requirements of the DHS PREA standards and shall document a cross-gender pat search if an exigent circumstance arises." Interviews with six security line staff indicated cross-gender pat-down searches are prohibited, unless there are exigent circumstances, and if conducted must be documented. The Auditor interviewed 20 detainees and confirmed, upon arrival at the facility each detainee, had received a pat-down search conducted by staff of the same gender. In addition, the Auditor observed a pat-down search of a detainee and confirmed it had been conducted by a staff member of the same gender. ICAF does not house female detainees.

(e)(f): ICAF policy ICAF-DO-06 states, "Cross-gender strip searches are strictly prohibited, and visual body cavity searches shall not be conducted except when performed by medical practitioners. All strip searches and visual body cavity searches shall be documented." Interviews with six security line staff indicated cross-gender strip searches, visual body cavity searches, and cross-gender visual body cavity searches are prohibited, unless there are exigent circumstances, and if conducted must be documented. Interviews with 20 detainees indicated one detainee had been strip searched at the facility the search was conducted by two male officers. The Auditor reviewed the "Record of Search" form and confirmed the search, and reason for the search had been documented.

(g): ICAF policy ICAF-DO-06 states, "FDC has implemented policies and procedures that enable detainees to shower, 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 cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Additionally, FDC policy requires staff of the opposite gender to 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 two holding cells in the medical area that contained mirrors directly across from the toilet and allowed for cross-gender viewing while the detainee performed bodily functions. However, upon notification of the deficiency the facility immediately removed the mirrors. During the on-site audit the Auditor further observed cells located in PC had large windows, which allowed viewing of the toilet areas; however, the Auditor reviewed the PC Housing Unit Officer post order and confirmed only male staff can be assigned to PC. During the on-site audit, the Auditor further observed female staff announcing their presence when entering the housing units. Interviews with 20 detainees, indicated multiple answers to include: opposite gender announcements are made, detainees don't hear an announcement, and staff do not announce at all. However, most detainees interviewed confirmed female staff do not enter the housing unit unless assigned to the housing unit during their shift.

**Recommendation (g):** The Auditor recommends staff of the opposite gender are announced over an intercom system so that all detainees are aware they are entering the housing units.

(h): ICAF is not a designated Family Residential Facility; and therefore, subsection (h) is not applicable.

(i)(j): ICAF policy ICAF-DO-06 states, "Facility staff assigned to the FDC shall not search or physically examine a detainee for the sole purposes of determining the detainee's genital characteristics. If the detainee's gender is unknown, it will be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. All facility staff shall receive training on the above stipulations and requirements of this subpart of DHS PREA

standard 115.15." The Auditor reviewed the Frisk/Strip Search Procedures training curriculum and confirmed the curriculum includes the standards requirements not to search or physically examine a detainee for the sole purpose of determining a detainee's genital characteristics and if the detainee's gender is unknown, it will be determined during conversation with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedures conducted in private, by a medical practitioner. A review of the Frisk/Strip Search Procedures further confirms it requires all searches be conducted in a professional and competent manner and officers will always respect and ensure the dignity of the detainee is maintained by employing the least intrusive manner possible during the search, consistent with security needs, policy, and officer safety. Interviews with the PSA Compliance Manager and six security line staff, indicated they have received training on how to conduct pat-down searches, including pat-down searches of a transgender or intersex detainees, in a professional and respectful way. During the on-site audit the Auditor reviewed a facility training log which confirmed all security staff have received Frisk/Strip Search Procedure training for the years 2022 and 2023.

**Corrective Action:**

No corrective action needed.

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

**Outcome:** Meets Standard

**Notes:**

(a)(b): ICAF policy ICAF-DO-06 states, "FDC shall ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. These steps and measures include effective communication with detainees who are deaf or hard of hearing, providing access to in-person, telephonic language line communication services, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Additionally, FDC shall ensure that any written materials related to sexual abuse are provided in formats or through methods that ensure effective communication with detainees with disabilities, including detainees who have intellectual disabilities, limited reading skills, or who are blind or have low vision." ICAF policy ICAF DO-06 further states, "Likewise, FDC shall take steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic language line interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary." No detainees were processed during the on-site audit; however, the Auditor observed a recorded video of a detainee being processed into the facility and confirmed the detainee had received the ICE National Detainee Handbook, the facility handbook, and the DHS-prescribed Sexual Abuse Awareness (SAA) Information pamphlet in his preferred language, Spanish. Interviews with the facility PSA Compliance Manager and Intake Processing Supervisor, indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the facility sexual abuse prevention and response, to include but not limited to, the use of the ERO Language Line for detainees who are LEP or have limited reading skills; a Teletypewriter (TTY) for detainees who are deaf or hard of hearing; and PREA information in Braille for detainees who are blind or have low vision. The PSA Compliance Manager further indicated that if a detainee had intellectual or psychiatric disabilities, staff would speak slowly and ask the detainee to repeat the information back to ensure that effective communication is established. Interviews with six security line staff confirmed they could articulate the multiple resources available to ensure effective communication with the detainees. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, the DHS-prescribed (SAA) Information pamphlet, consulate posters, the DRIL poster, DHS OIG poster, and the YWCA Sexual Assault Response Program flyer, posted on the wall in all detainee housing units. In addition, the Auditor observed the facility had an ample supply of the ICE National Detainee handbooks, available in the 14 of the most prevalent languages encountered

by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and the DHS-prescribed SAA Information pamphlet available in the 15 most prevalent languages encountered by ICE, specifically Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian. The Auditor further observed the Farmville Detention Center Detainee Handbook, available in English and Spanish, and the Detainee Orientation PowerPoint, available in Amharic, Arabic, Bambara, Bengali, Creole, Dutch, Farci, French, Gujarati, Hindi, Hungarian, Korean, Mandarin Chinese, Mongolian, Portuguese, Punjabi, Tamil, Thia, Tigrigna, Turkish, Twi, Urdu, and Vietnamese. In an interview with the PSA Compliance Manager, it was indicated if a detainee's preferred language was a language other than English, Spanish, or not included in the available Detainee Orientation PowerPoint, the facility would utilize the ERO Language Line to provide the information to the detainee. The PSA Compliance Manager further indicated when the ERO Language Line is utilized a staff member would read the presentation, which includes the information included in the facility detainee handbook, to the detainee to be translated by an interpreter in the detainee's preferred language and the entire phone call would be recorded and saved on the facility network for future use by a detainee needing the same interpretive services. In addition, in an interview with the PSA Compliance Manager it was indicated if the detainee's preferred language was not one on the 14 most prevalent languages encountered by ICE the same process would be followed by staff to ensure the detainee was receiving the information included in the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet. During interviews with 20 detainees, including 1 detainee whose preferred language was French, it was confirmed all were provided PREA information in a manner they could understand. Interviews with 20 detainees further indicated they were provided an ID card upon intake which included phone numbers for the facility PREA Hotline, the DRIL, DHS OIG and the YWCA.

(c): ICAF policy ICAF-DO-06 states, "In matters relating to allegations of sexual abuse, FDC shall provide in-person or telephonic language line interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation, and the Director of Detention determines that such interpretation is appropriate and consistent with DHS policy and the 2011 ICE PBNDS." Interviews with six security line staff, confirmed in matters relating to allegations of sexual abuse, they would not use a detainee to interpret under any circumstances. Upon notification of the deficiency the facility Director immediately uploaded to the facility Power DMS (Document Management System) a memorandum to all staff reminding them of facility policy to allow another detainee to interpret for a detainee in matters relating to sexual abuse requiring staff to review the memorandum and acknowledge their review by signature.

**Recommendation (c):** The Auditor recommends that the facility update ICAF policy ICAF-DO-06 to include the requirement that the Agency determines if the interpretation is appropriate and not the facility Director to coincide with the facility Power DMS (Document Management System) memorandum to all staff to adhere to the standards requirement…unless the detainee expresses a preference for another detainee to provide interpretation, and the Agency determines that such interpretation is appropriate and consistent with DHS policy."

**Corrective Action:**

No corrective action needed.

**§115.17 - Hiring and promotion decisions**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance

level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." ICAF policy ICAF-DO-06 states, "FDC shall not hire or promote anyone who may have contact with detainees, and shall not enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. When considering the hiring or promotion of staff, FDC shall ask all applicants who may have contact with detainees directly about previous misconduct described in the above paragraph, in written applications or interviews for hiring or promotions and during annual PREA training review of current employees. Additionally, FDC shall also require and impose upon employees a continuing affirmative duty to disclose any such misconduct. The Human Resource Manager, consistent with law, shall make its best efforts to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. 3. Before hiring new staff, who may have contact with detainees, FDC shall conduct a background investigation to determine whether the candidate for hire is suitable for employment with the facility, including a criminal background records check." The Auditor reviewed the FDC Sexual Assault and Abuse Prevention and Intervention Program curriculum which includes: "detention officer has an obligatory and continuing duty to disclose any such misconduct. Material omissions regarding such misconduct or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate." An interview with the HRM indicated that once an applicant, to include contractors and volunteers, have completed a successful interview, the applicant, contractor, or volunteer is provided multiple forms to complete including the DHS 6 Code of Federal Regulations Part 115. The Auditor reviewed the DHS 6 Code of Federal Regulations Part 115 and confirmed the form asks the applicant; "have you ever engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution as defined in 42 USC 1997; have you ever been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion; have you ever been convicted of engaging or attempting to engage in sexual activity where the victim did not consent or was unable to consent or refuse; have you ever had a civil or administrative adjudication against you for engaging in activity described in questions 1 and 3." A review of the DHS 6 Code of Federal Regulations Part 115 form further confirmed the applicant must acknowledge by signature a knowing or willfully false response may result in a negative finding regarding their fitness as a contract employee supporting ICE. In addition, a review of the DHS 6 Code of Federal Regulations Part 115 form confirmed the form informs the applicant should the answers change at any time they are responsible for immediately reporting the information to the Program Manager. An interview with the HRM indicated during the initial application process, applicants are asked about prior employment and if the applicant has worked for another institutional employer, he will ask for information on possible substantiated allegations involving the applicant. The HRM further indicated he would provide the same information if he was contacted by another institutional employer. In addition, an interview with the HRM indicated all applicants, including contractors, must complete a background check through ICE Personal Security Unit (PSU). The Auditor submitted 21 names, which included facility staff, ICE staff, and contract staff, to PSU for confirmation of completed background checks and five year rechecks. The Auditor received confirmation that all 21 names submitted had received an initial background check and 18 were eligible and received a five-year recheck. In

addition, the Auditor reviewed 15 personnel files which included 2 contract staff and confirmed each employee and contractor had a background check conducted and completed the DHS 6 Code of Federal Regulations Part 115 form at the time of hire. A review of 15 personnel files which included 2 contract staff and 1 volunteer file further confirmed each employee, contractor, and volunteer completed the DHS 6 Code of Federal Regulations Part 115 form on an annual basis. In addition, the Auditor reviewed the personnel file of a recently promoted staff member and confirmed the staff member completed the DHS 6 Code of Federal Regulations Part 115 form prior to his promotion. In an interview with the SDDO it was indicated there have not been any promotions of ICE staff during the audit period.

**Corrective Action:**

No corrective action needed.

**§115.18 - Upgrades to facilities and technologies**

**Outcome:** Meets Standard

**Notes:**

(a): ICAF policy ICAF-DO-06 states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, FDC shall consider the effect of the design, acquisition, expansion, or modification upon their ability to protect detainees from sexual abuse." Interviews with the facility Director and the PSA Compliance Manager indicated the facility has not designed, acquired, or made any substantial expansions or modifications, since the facility's last DHS PREA Audit in January of 2021. During the on-site audit, the Auditor did not observe any recent construction of the facility.

(b): ICAF policy ICAF-DO-06 states, "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology FDC shall consider how such technology may enhance their ability to protect detainees from sexual abuse." Interviews with the facility Director and the PSA Compliance Manager indicated the facility is in the process of upgrading the video monitoring system from analog to digital to allow for the retention of (b) (7)(E) allowing ICAF to enhance its ability to protect detainees from sexual abuse; however, the installation is not complete.

**Corrective Action:**

No corrective action needed.

**§115.21 - Evidence protocols and forensic medical examinations**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d): The Agency's policy 11062.2, outlines the Agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." ICAF policy ICAF-DO-06 states, "FDC follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for internal administrative proceedings and criminal prosecutions by the Commonwealth Attorney's Office for Prince Edward County. These protocols are outlined and described in Section P through R of this policy, have been developed in coordination with DHS, and these protocols are posted on the facility's website for availability to the public, http://ica-farmville.com/?page_id=159. FDC shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse." ICAF policy ICAF-DO-06 further states, "FDC has a Cooperative Agreement (See Appendix C) with the YWCA Sexual Assault Response Program which provides expertise and support services for immigrant victims of crime including 24-hour crisis intervention,

victim advocacy, group and individual counseling, legal assistance, and many other support services for victims of sexual abuse. In accordance with the 2011 ICE PBNDS, FDC shall also attempt to make these victim services available for any detainee identified as having experienced sexual victimization prior to entering DHS custody or if a detainee experienced sexual victimization elsewhere in ICE custody." In addition, ICAF policy ICAF-DO-06 states, "Upon a detainee's consent, the YWCA Sexual Assault Response Program shall be contacted to assist with the facility's sexual abuse prevention and intervention protocols to include the presence of the victim advocate for support during any forensic exam or investigatory interview with the agreement of the detainee victim." An interview with the PSA Compliance Manager and the HSA indicated with the victim's consent, a victim of sexual abuse would be transported to the Centra Lynchburg General Hospital for emergency medical treatment and for a sexual abuse forensic exam (SAFE). The Auditor reviewed a voice mail to Centra Lynchburg General Hospital, requesting the facility to provide SANE and/or SAFE services; however, the facility provided a memo that confirmed ICAF did not receive a response to the voicemail. Therefore, the Auditor reviewed the hospital website and confirmed sexual abuse forensic exams would be completed by a SAFE. The Auditor reviewed an open ended, with the clause that either party can terminate the agreement with a 30-day written notice, Cooperative Agreement between YWCA Sexual Assault Response Program and ICAF, dated February 17, 2023, which confirms YWCA would provide detainee victims of sexual assault accompaniment services (e.g., accompaniments to forensic sexual assault exams and criminal and/or civil legal proceedings, protective order hearings, preliminary hearings, sentencing hearings, and other relevant legal proceedings related to sexual victimizations). In an interview with a YWCA victim advocate it was confirmed the YWCA would accompany the detainee to Centra Lynchburg General Hospital where a SAFE exam would be conducted. The advocate from YWCA further indicated the YWCA would provide the detainee victim advocacy and support services during the SAFE exam and any investigative interviews. The Auditor reviewed one allegation of sexual abuse investigation file and confirmed the detainee victim did not require a forensic exam following the allegation of sexual abuse. Interviews with the facility Director and SDDO confirmed ICAF policy ICAF-DO-06 was developed in consultation with DHS.

(e): ICAF policy ICAF-DO-06 states, "Since FDC is not responsible for conducting criminal or potential criminal investigations into allegations of sexual abuse, the facility will request that the Farmville Police Department follow the requirements and stipulations set forth in this policy, the 2011 ICE PBNDS, and DHS PREA Standards." The Auditor reviewed an open ended, with the clause that either party can terminate the agreement with a 30-day written notice, Cooperative Agreement between the Farmville Police Department (FPD) and ICAF, dated February 20, 2020, which confirmed ICAF has requested the FPD follow paragraphs a – d of the standard. In a review of one sexual abuse allegation investigation file, it was confirmed the allegation was not criminal in nature; and therefore, the FPD was not notified.

**Corrective Action:**

No corrective action needed.

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

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d)(e)(f): The Agency provided policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary. b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to

procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." ICAF policy ICAF-DO-06 states, "If the allegation is criminal or potentially criminal in nature, the Farmville Detention Center shall promptly refer the incident to the Farmville Police Department. The Farmville Detention Center shall suspend the internal administrative investigation until the conclusion of the Farmville Police Department's criminal investigation as to not compromise or interfere with their investigation. Regardless of whether the Farmville Police Department's criminal investigation into an allegation of sexual abuse or assault is substantiated, unsubstantiated, or unfounded the Farmville Detention Center shall conduct an internal administrative investigation and request copies of all relevant investigative reports and documents from this law enforcement agency." ICAF policy ICAF DO-06 further states, "(a) All documentation collected and obtained from the criminal investigation by the Farmville Police Department and internal administrative investigation by the Farmville Detention Center shall be maintained for at least five years, which includes all reports and referrals on allegations of sexual abuse. b) The Farmville Detention Center shall retain all reports and documentation on the alleged abuser while he or she is detained at FDC or employed by FDC, plus five years." In addition, ICAF policy ICAF DO-06 states, "All Farmville Detention Center administrative investigations shall be conducted after consultation with ICE and for any incident referred to the Farmville Police Department" and "the Farmville Police Department will also be notified that the facility intends to conduct an internal administrative investigation." In addition, ICAF policy ICAF-DO-06 states, "In accordance with the reporting requirements under DHS PREA Standard 115.22 paragraphs 5 and 6, the Director of Detention shall promptly notify the ICE Field Office Director or Assistant Field Office Director of a sexual abuse or assault incident involving either a detainee or staff, contractor, or volunteer perpetrator with an alleged detainee victim. a) During this notification, the Director of Detention will also remind the individual contacted that provisions in the standards require that the incident of sexual abuse or assault needs to be promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General." An interview with the PSA Compliance Manager/Investigator indicated allegations criminal in nature would be immediately reported to the FPD and an administrative investigation would be completed in consultation with the FPD. The PSA Compliance Manager further indicated there has not been an allegation of sexual abuse requiring a report be made to the FPD during the audit period. The Auditor reviewed the PREA allegation spreadsheet and confirmed there was one closed allegation of sexual abuse reported during the audit period. The PREA allegation spreadsheet further confirmed the allegation was determined to be unsubstantiated and the Joint Intake Center (JIC) was notified of the allegation; however, a date was not provided as to when ERO was notified noting "N/A." In addition, a review of the PREA Allegation Spreadsheet indicated the allegation was investigated by an Agency investigator. The Auditor reviewed one sexual abuse allegation investigation file that included contract staff-on-detainee and confirmed notifications had been made to the FOD, the Joint Intake Center and ICE OPR; however, the allegation was not criminal in nature; and therefore, the FPD was not notified. The Auditor reviewed the Agency website (https://www.ice.gov/prea) and the facility website (https://ica-farmville.com/?page_id=159) and confirmed the Agency and facility protocols have been posted as required by subsection (c) of the standard.

**Corrective Action:**

No corrective action needed.

**§115.31 - Staff Training**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c): The Agency's policy 11062.5.2 states, "The Agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed training." ICAF policy ICAF-DO-06 states, "Training on the Farmville Detention Center Sexual Abuse and Assault Prevention and Intervention Program will be included in basic training for all employees, volunteers, and contract personnel and will also be included in annual refresher training." ICAF policy ICAF-DO-06 further states, "Training will include: 1. Definitions and examples of prohibited and illegal sexual behavior; 2. Knowledge and awareness that the Farmville Detention Center has a strict zero-tolerance policy for all forms of sexual abuse; 3. The right of detainees and staff to be free

from sexual abuse, and the prohibition from retaliation for reporting sexual abuse; 4. Instruction that sexual abuse and assault is never an acceptable consequence of detention; 5. Recognition of situations where sexual abuse and assault may occur; 6. Recognition of the physical, behavioral and emotional signs of sexual abuse and assault and methods of preventing and responding to such occurrences; 7. How to avoid inappropriate relationships with detainees; 8. The requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee victim's welfare, and for law enforcement investigative purposes; 9. The investigation process and how to ensure that evidence is not destroyed; 10. Prevention, recognition, and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; 11. Instruction on reporting knowledge or suspicion of sexual abuse and assault and making intervention referrals to the facility's Sexual Abuse and Assault Prevention and Intervention program; 12. Instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and assault; and 13. How to communicate effectively and interact professionally with detainees with specific emphasis on detainees identified as lesbian, gay, bisexual, transgender, intersex, or gender nonconforming (LGBTI)." An interview with the PSA Compliance Manager indicated staff are required to complete PREA training on an annual basis. The Auditor reviewed the ICAF Sexual Assault and Abuse Prevention and Intervention Program training curriculum for staff and contract staff and confirmed all elements required by subsection (a) of the standard are included. In addition, the facility provided the Auditor a computerized print-out confirming all staff and contract staff to include security line staff, medical and mental health, food service, commissary, and supervisory staff had attended Sexual Abuse and Assault Prevention (SAAPI/PREA/LGBTI) training for the years 2022 and 2023. In addition, the Auditor reviewed training certificates which confirmed seven ICE staff members have also received the required training. Interviews with six security line staff confirmed they were knowledgeable regarding PREA and fulfilling their responsibilities under the PREA standards.

**Recommendation (a):** The Auditor recommends the facility update ICAF policy ICAF DO-06 to include the requirement to advise staff and contractor staff of the Agency zero-tolerance policy that is included in their training curriculum.

**Corrective Action:**

No corrective action needed.

**§115.32 - Other Training**

**Outcome:** Does Not Meet Standard

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "Training on FDC's Sexual Abuse and Assault Prevention and Intervention Program will be included in basic training for all employees, volunteers, and contract personnel and will also be included in annual refresher training. When educating volunteers and other contractors who have contact with detainees, FDC shall ensure these individuals have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed how to report such incidents. In this paragraph "other contractor" means a person who provides services on a non-recurring basis to the facility pursuant to a contractual agreement with the facility. The Training Manager will maintain written documentation verifying employee, volunteer, and contractor training." The Auditor reviewed the facility Volunteer Orientation Training curriculum and confirmed the curriculum includes indicators of sexual assault and that an incident of sexual abuse must be reported; however, a review of the Volunteer Orientation Training curriculum could not confirm the training curriculum notifies volunteers and "other" contractors of the Agency and facility zero-tolerance policies or how to report an incident of sexual abuse. The Auditor reviewed the files of one volunteer and one "other" contractor and confirmed both had received Volunteer Orientation Training; however, the training is not compliant with subsection (b) of the standard. In an interview with the PSA Compliance Manager it was confirmed "other"

contractors, as described in subsection (d) of the standard who provide services on a non-recurring basis to the facility pursuant to a contractual agreement with the Agency or facility are escorted by staff; and therefore, have not been trained on their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures.

**Corrective Action:**

The facility is not in compliance with subsections (a) and (b) of the standard. The Auditor reviewed the facility Volunteer Orientation Training curriculum and confirmed the curriculum includes indicators of sexual assault and that an incident of sexual abuse must be reported; however, a review of the Volunteer Orientation Training curriculum could not confirm the training curriculum notifies volunteers and "other" contractors of the Agency and facility zero-tolerance policies or how to report an incident of sexual abuse. The Auditor reviewed the files of one volunteer and one "other" contractor and confirmed both had received Volunteer Orientation Training; however, the training is not compliant with subsection (b) of the standard. In an interview with the PSA Compliance Manager it was confirmed "other" contractors, as described in subsection (d) of the standard who provide services on a non-recurring basis to the facility pursuant to a contractual agreement with the Agency or facility are escorted by staff; and therefore, have not been trained on their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures. To become compliant the facility must update the Volunteer Orientation Training to include the standard's requirements to notify volunteers and "other" contractors of the Agency and facility zero-tolerance policies and how to report an incident of sexual abuse. In addition, the facility must provide documentation the confirms all volunteers and "other contractors" as described in subsection (d) of the standard, regardless of whether or not they are escorted by staff have been trained on the updated curriculum.

## §115.33 - Detainee Education

**Outcome:** Exceeds Standard

**Notes:**

(a)(b)(c)(d)(e)(f): ICAF policy ICAF-DO-06 states, "The Director will ensure that the orientation program, required by the detention standard on Admission and Release and the handbook required by the detention standard on detainee handbook, notifies and informs detainees about the FDC's zero tolerance policy for all forms of sexual abuse and assault and how to report such incidents. Following the intake process, the facility will provide instruction to detainees on the facility's Sexual Abuse and Assault Prevention and Intervention Program and ensure that such instruction includes: 1. The facility's zero tolerance policy for all forms of sexual abuse or assault; 2. Prevention and intervention strategies; 3. Definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; 4. Explanation of methods for reporting sexual abuse or assault to any staff member or outside entities, including a staff member other than an immediate point of contact Detention Officer such as the PSA Compliance Manager, Mental Health Specialist, Medical staff, Investigators, on site ICE Officials, Chaplains, the DHS Office of Inspector General, ICE Joint Intake Center, ICE Detention Reporting and Information Line, and the ICE/OPR for investigation purposes and processes; 5. Information about self-protection and indicators of sexual abuse; 6. Prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and 7. Right of a detainee who has been subjected to sexual abuse or assault to receive treatment and counseling." ICAF policy ICAF-DO-06 further states, "The ICE/ERO provided sexual assault awareness notice will be posted in every housing unit, and the ICE "Sexual Assault Awareness Information" pamphlet will be distributed during initial intake. The Sexual Assault Awareness notice, Appendix B in this policy, will also be posted in every housing unit along with the name of the Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager) and contact information for the YWCA Sexual Assault Response Program which provides numerous victim support services for detainees who have been victims of sexual assault. Information about reporting sexual abuse is also included in the FDC detainee handbook and as well as on the back of all detainee identification badges. Detainee notification, orientation and instruction will be in a language or manner that the detainee understands. The facility will maintain documentation of detainee participation in the instruction session. This information will be provided in English and Spanish and to other segments of the detainee population with limited

English proficiency, through translations or oral interpretation including education to detainees who are deaf, visually impaired, or otherwise disabled, and detainees possessing limited reading skills." No detainees were processed during the on-site audit; however, the Auditor observed a recorded video of a detainee being processed into the facility and confirmed the detainee had received the ICE National Detainee Handbook, the facility handbook, and the DHS-prescribed Sexual Abuse Awareness (SAA) Information pamphlet in his preferred language, Spanish. The Auditor reviewed the facility Orientation PowerPoint and confirmed all elements required by subsection (a) of the standard are included. In addition, the Auditor reviewed the ICE National Detainee handbook and confirmed it includes information on how to report an allegation. Interviews with the PSA Compliance Manager and Intake Processing Supervisor, indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the facility sexual abuse prevention and response policies, to include but not limited to, the use of the ERO Language Line for detainees who are LEP or have limited reading skills; TTY phone for detainees who are deaf or hard of hearing; and PREA information in Braille for detainees who are blind or have low vision. The PSA Compliance Manager further indicated that if a detainee had intellectual or psychiatric disabilities, staff would speak slowly and ask the detainee to repeat the information back to ensure that effective communication is established. Interviews with six security line staff confirmed they could articulate the multiple resources available to ensure effective communication with the detainees. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, the DHS-prescribed SAA Information pamphlet, consulate posters, the DRIL poster, DHS OIG poster, and the YWCA Sexual Assault Response Program flyer, posted in all detainee housing units. In addition, the Auditor observed the facility had an ample supply of the ICE National Detainee handbooks, available in the 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese and the DHS-prescribed SAA Information pamphlet available in the 15 most prevalent languages encountered by ICE, specifically Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian. The Auditor further observed the Farmville Detention Center Detainee Handbook, available in English and Spanish, and the Detainee Orientation PowerPoint, available in Amharic, Arabic, Bambara, Bengali, Creole, Dutch, Farci, French, Gujarati, Hindi, Hungarian, Korean, Mandarin Chinese, Mongolian, Portuguese, Punjabi, Tamil, Thia, Tigrigna, Turkish, Twi, Urdu and Vietnamese. In an interview with the PSA Compliance Manager, it was indicated if a detainee's preferred language was other than English, Spanish, or not included in the available Detainee Orientation PowerPoint, the facility would utilize the ERO Language Line to provide the information to the detainee. The PSA Compliance Manager further indicated when the ERO Language Line is utilized a staff member would read the presentation, which includes the information included in the facility detainee handbook, to the detainee to be translated by an interpreter in the detainee's preferred language and the entire phone call would be recorded and saved on the facility network for future use by a detainee needing the same interpretive services. In addition, in an interview with the PSA Compliance Manager it was indicated if the detainee's preferred language was not one on the 14 most prevalent languages encountered by ICE the same process would be followed by staff to ensure the detainee was receiving the information included in the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet. An interview with the Intake Processing Supervisor indicated detainee orientation is documented on the ICAF Detainee Visiting Waiver. The Auditor reviewed the "ICA Detainee Visiting Waiver" and confirmed it includes, "I have viewed (listened to) the orientation presentation and further understand the Farmville Detention Center facility policies, rules, prohibited acts, and procedures. Additionally, the orientation presentation has been presented in a language or manner that I understand. I have also been made aware and informed the Farmville Detentions Center's Sexual Abuse and Assault Prevention and Intervention Program." During interviews with 20 detainees, including 1 detainee whose preferred language was French, it was confirmed all were provided PREA information in a manner they could understand. Interviews with 20 detainees further confirmed they were provided an ID card upon intake that included phone numbers for the facility PREA Hotline, the DRIL, DHS OIG and the YMCA. The Auditor reviewed 20 detainee files and confirmed the detainee had acknowledged and signed the "ICA Detainee Visiting Waiver" during the intake process. Upon review of all submitted documentation to include providing detainees with an ID card upon intake

which includes phone numbers for the facility PREA Hotline, the DRIL, DHS OIG and the YMCA the Auditor has determined the facility exceeds standard 115.33.

**Recommendation (a):** The Auditor recommends the facility update ICAF policy ICAF DO-06 to include the requirement to advise detainees of the Agency zero-tolerance policy which is included in the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet distributed by ICAF during the intake process.

**Corrective Action:**

No corrective action needed.

**§115.34 - Specialized training: Investigations**

**Outcome:** Meets Standard

**Notes:**

(a)(b): The Agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. ICAF policy ICAF-DO-06 states, "Facility policy requires that the security staff member who conducts the investigation be qualified and has received specialized investigative training on sexual abuse and effective cross-agency coordination as stipulated under the conditions of DHS PREA Standard 115.34. At a minimum, this specialized investigative training shall cover a) Interviewing sexual abuse and assault victims; b) Sexual abuse and assault evidence collection in confinement settings; c) The criteria and evidence required for administrative action or prosecutorial referral and d) Information about effective cross-agency coordination in the investigation process. FDC will maintain written documentation verifying specialized training provided to investigators." A review of the facility PAQ indicates the facility has four investigators who have received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed the America Jail Association Finding the Truth: Investigations of Sexual Abuse of inmates in a Confinement Setting and confirmed the curriculum includes interviewing sexual abuse and assault victims; sexual abuse and assault evidence collection in confinement settings; 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/Investigator confirmed his knowledge and his qualifications for investigating sexual abuse allegations in the facility. The Auditor reviewed four training certificates and confirmed each of the facility investigators have completed the required specialized training. In addition, the Auditor reviewed staff training records which confirmed each investigator had completed the facility general PREA training required by §115.31. The Auditor reviewed the PREA Allegation Spreadsheet and confirmed the one reported allegation of sexual abuse investigation was completed by an Agency investigator. In addition, the Auditor reviewed the Agency investigator training roster and confirmed the Agency investigator received the required specialized training.

**Corrective Action:**

No corrective action needed.

**§115.35 - Specialized training: Medical and mental health care**

**Outcome:** Does Not Meet Standard

**Notes:**

(a): ICAF does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners; and therefore, subsection (a) of the standard is not applicable.

(b)(c): ICAF policy ICAF-DO-06 states, "While some victims can be clearly identified, many, or even most, may not come forward directly with information. Some victims may be identified through unexplained injuries, changes in physical behavior due to injuries, abrupt personality changes such as withdrawal or suicidal behavior, or other changes in behavior. In accordance with DHS PREA standard 115.35, medical and mental health care staff will receive specialized training, subject to the review and approval of the Field Office Director or other designated ICE Official, on the following components of FDC's Sexual Abuse and Assault Prevention and Intervention program: a) Procedures for examining victims of sexual abuse. b) Procedures for treating victims of sexual abuse. c) How to detect, assess, and respond to signs of sexual abuse and sexual harassment effectively and professionally. d) How and to whom to report allegations or suspicions of sexual abuse. e) How to preserve physical evidence of sexual abuse." An interview with the HSA indicated all medical and mental health staff are required to attend specialized training and complete general PREA training as required by §115.31. The HSA provided the Auditor a certificate which confirmed she has received training in Rape/Sexual Assault; however, a training curriculum was not provided. The Auditor reviewed a computerized print-out confirming each medical and mental health staff had completed Sexual Abuse and Assault Prevention (SAAPI/PREA/LGBTI) training; however, a review of exhibits provided by the facility and two medical staff training files could not confirm medical and mental health staff have completed specialized training to include procedures for examining victims of sexual abuse; procedures for treating victims of sexual abuse; how to detect, assess, and respond to signs of sexual abuse and sexual harassment effectively and professionally; how and to whom to report allegations or suspicions of sexual abuse; and how to preserve physical evidence of sexual abuse. A review of a memorandum to the file and interviews with the facility Director and SDDO confirmed ICAF policy ICAF-DO-06 has been reviewed and approved by the Agency.

**Corrective Action:**

The facility is not in compliance with subsection (b) of the standard. The HSA provided the Auditor a certificate indicating that she had received training in Rape/Sexual Assault; however, a training curriculum was not provided. The Auditor reviewed a computerized print-out confirming each medical and mental health staff had completed Sexual Abuse and Assault Prevention (SAAPI/PREA/LGBTI) training; however, a review of exhibits provided by the facility and two medical staff training files could not confirm medical and mental health staff have completed specialized training as required by subsection (b) of the standard. To become compliant, the facility must provide the Auditor with a specialized training curriculum which includes the required elements of subsection (b) of the standard. In addition, the facility must provide documentation that confirms all medical and mental health staff have received the required training.

**§115.41 - Assessment for risk of victimization and abusiveness**

**Outcome:** Does Not Meet Standard

**Notes:**

(a)(b)(g): ICAF policy ICAF-DO-06 states, "Detainees will be screened, classified, and initially housed by staff within 12 hours of arrival at the facility. The purpose of this screening is to identify those likely to be sexual aggressors or sexual victims and detainees will be housed accordingly to prevent sexual abuse or assault. Detainees who are considered likely to become victims will be placed in the least restrictive housing that is available and appropriate." ICAF policy ICAF-DO-06 further states, "In accordance with the SOPs on Admission and Release and Custody Classification System: each new arrival will be kept separate from the general population until he or she is classified and may be housed accordingly. Detainees who have been identified as being at risk for sexual victimization shall be immediately referred to a qualified Mental Health professional for further assessment, treatment and/or counseling." In addition, ICAF policy ICAF-DO-06 states,

"Responses to questions and material collected on ICA Form 74 are considered sensitive information and therefore staff have an obligation to keep this data confidential. Staff shall only disseminate information captured on ICA Form 74 on a need-to-know basis to prevent the exploitation of material to a detainee's detriment by staff or other detainees." An interview with the PSA Compliance Manager indicated the "PREA Assessment Tool for Risk of Victimization and Abusiveness" is completed upon intake. An interview with the PSA Compliance Manager further indicated detainees do not receive their initial housing assignment until the completion of the initial risk assessment which is completed within 12 hours as required by subsection (b) of the standard. In addition, the PSA Compliance Manager indicated detainees are kept separate from detainees housed in general population until initially housed following the completion of the risk assessment. The PSA Compliance Manager further indicated the facility Offender Management System (OMS) is designed to track the detainee who has been identified as being vulnerable to sexual abuse by placing a V Code into the system or a P Code to track detainees identified to be sexual aggressors. In interviews with the PSA Compliance Manager, it was further indicated access to answers provided to questions on the initial risk assessment, and PREA codes are limited to the PSA Compliance Manager, facility Investigators, and the Intake Processing staff; however, the PSA Compliance Manager could not articulate the procedure to follow to ensure a detainee identified as being vulnerable to sexual abuse and a detainee identified as being a sexual aggressor would be housed separately. In addition, during an interview with the Intake Processing Supervisor, it was confirmed she could not articulate how the information gained from the initial risk assessment is used to determine initial housing including how the OMS codes used to identify the detainee vulnerable to sexual abuse or sexual aggression could or would affect the initial housing assignment of the detainee. The Auditor reviewed 20 detainee files and confirmed an initial risk assessment had been completed for each detainee; however, 2 of the reviewed files confirmed the initial risk assessment had been completed 2 days after the initial intake date; 2 of the files confirmed the assessment had been completed the day before the detainee's arrival to the facility, and 1 file did not include the date the initial risk assessment had been completed; and therefore, a review of the files could not confirm the initial risk assessment was completed in accordance with subsections (a) and (b) of the standard even though the detainees had been given an initial housing assignment which included co-mingling with general population detainees.

(c)(d)(f): ICAF policy ICAF-DO-06 states, "Completion of ICA Form 74: PREA Assessment Tool for Risk of Victimization and Abusiveness, which contains all required screening informational questions and data collection criteria found in DHS PREA Standard 115.41 (See Appendix F). The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive." ICAF policy ICAF-DO-06 further states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions A), G), H), and I) asked on ICA Form 74." The Auditor reviewed the "PREA Assessment Tool for Risk of Victimization and Abusiveness" and confirmed the assessment tool includes whether the detainee has a mental, physical or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; whether the detainee has self-identified as having previously experienced sexual victimization; the detainees own concerns about his safety; prior acts of sexual abuse; prior convictions for violent offenses; and whether the detainee had a history of prior institutional violence or sexual abuse. In an interview with the PSA Compliance Manager, it was confirmed detainees are not disciplined for refusing to answer or giving incomplete information during the initial risk assessment.

(e): ICAF policy ICAF-DO-06 states, "FDC shall reassess each detainee's risk of victimization or abusiveness between 60 to 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." Interviews with the Intake Processing Supervisor and PSA Compliance Manager indicated that a reassessment is conducted with all detainees between 60-90 days of the initial risk assessment utilizing the "PREA Assessment Tool for Risk

of Victimization and Abusiveness". The PSA Compliance Manager further indicated a reassessment is completed if warranted based on the receipt of new information or following an incident of sexual abuse. The Auditor reviewed 20 detainee files and confirmed 2 detainees had been housed at the facility over 60 days and a reassessment had been completed as required by subsection (e) of the standard. The facility provided the Auditor, an assessment that had been completed after the detainee had reported an incident of sexual abuse which had occurred while housed at another facility.

**Corrective Action:**

The facility is not in compliance with subsections (a) and (b) of the standard. During interviews the PSA Compliance Manager could not articulate the procedure to follow to ensure a detainee identified as being vulnerable to sexual abuse and a detainee identified as being a sexual aggressor would be housed separately. In addition, during an interview with the Intake Processing Supervisor, it was confirmed she could not articulate how the information gained from the initial risk assessment is used to determine initial housing including how the OMS codes used to identify the detainee vulnerable to sexual abuse or sexual aggression could or would affect the initial housing assignment of the detainee. The Auditor reviewed 20 detainee files and confirmed an initial risk assessment had been completed for each detainee; however, 2 of the reviewed files confirmed the initial risk assessment had been completed 2 days after the initial intake date; 2 of the files confirmed the assessment had been completed the day before the detainee's arrival to the facility, and 1 file did not include the date the initial risk assessment had been completed; and therefore, a review of the files could not confirm the initial risk assessment was completed in accordance with subsections (a) and (b) of the standard even though the detainees had been given an initial housing assignment which included co-mingling with general population detainees. In addition, the Auditor reviewed one sexual abuse investigation file and confirmed the detainee was not reassessed following an incident of sexual abuse or victimization. To become compliant the facility must submit documentation that confirms all applicable staff, to include Intake, Classification, and the PSA Compliance Manager have been trained on the standard's requirement to complete an initial assessment and classification of all detainees within 12 hours of arrival ensuring detainees who are identified as being vulnerable to sexual abuse or sexual aggression are housed to prevent sexual abuse. In addition, the facility must submit documentation that confirms all applicable staff, to include Intake, Classification, and the PSA Compliance Manager received training on the standard's requirement to ensure steps are taken to mitigate dangers of sexual abuse including keeping new arrivals separate from general population until the detainee has completed an initial assessment and is initially classified. The facility must provide the Auditor 10 detainee files to confirm initial housing and classification is completed as required by subsections (a) and (b) of the standard to include the use of the OMS to track detainees likely to be vulnerable to sexual abuse or sexual aggression to determine initial housing.

The facility is not in compliance with subsection (e) of the standard. The Auditor reviewed one sexual abuse investigation file and confirmed the detainee was not reassessed following an incident of sexual abuse or victimization. To become compliant, the facility must submit documentation that confirms all applicable staff, including facility investigators have been trained on the standard's requirement to reassess all detainees following an incident of sexual abuse or sexual victimization. In addition, if applicable, the facility must submit any sexual abuse allegation investigation files and the corresponding reassessment that occur during the corrective action plan (CAP) period.

**§115.42 - Use of assessment information**

**Outcome:** Does Not Meet Standard

**Notes:**

(a): ICAF policy ICAF-DO-06 states, "FDC shall use the information from ICA Form 74 for the purpose of determining and making an informed assignment of detainees to housing, recreation and other activities, and voluntary work. Individualized determinations shall be made on a case-by-case basis to ensure the safety of each detainee." An interview with the PSA Compliance Manager indicated the "PREA Assessment Tool for Risk of Victimization and Abusiveness" is completed upon intake. The PSA Compliance Manager further indicated information from the initial risk assessment is added to the OMS which is designed to track the detainee who has

been identified as being vulnerable to sexual abuse by placing a V Code into the system or a P Code to track detainees identified to be sexual aggressors. However, during interviews the PSA Compliance Manager and the Intake Processing Supervisor it was confirmed neither staff could articulate how the facility would utilize the information learned from the initial assessment to inform assignment of detainees to initial housing. The Auditor reviewed a "Volunteer Work Program Agreement", which states, "In accordance with the DHS PREA Standard §115.42 a review of the detainees risk assessment for victimization was conducted. This review concluded that the detainee is cleared to participate in the voluntary work program." The Auditor reviewed 20 detainee files and confirmed an assessment had been completed for each detainee; however, 2 of the files indicated the assessment had been completed two days after the detainee arrived at the facility and 1 detainee file did not include the date the initial risk assessment had been completed; and therefore, the Auditor could not confirm the information gathered from the initial risk assessment was utilized in determining assignment of initial housing. A review of 20 detainee files could not confirm the utilization of the OMS system and Volunteer Work Program Agreement as none of the files included detainees who were assigned to a voluntary work program.

(b)(c): ICAF policy ICAF-DO-06 states, "When making assessment and housing decisions for a transgender or intersex detainee, FDC shall consider the following criteria protocols: a) Detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. An interview shall be conducted on any transgender or intersex detainee to take into consideration detainee's health and safety needs. b) Consultation with medical and mental health as soon as practicable on this assessment. c) Assemble a multi-disciplinary committee consisting of key facility leadership, medical and mental health staff, and ICE personnel to convene and document FDC's decision on housing and other mitigating factors to best meet the safety and security needs of the detainee. d) FDC shall not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of gender and self-assessment of safety needs shall always be taken into consideration as well. e) The placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee shall be reassessed in accordance with FDC's Transgender Care policy." An interview with the facility PSA Compliance Manager indicated the facility has established a multidisciplinary Transgender Classification and Care Committee (TCCC) which is comprised of medical and mental health personnel, the PSA Compliance Manager, the Classification Supervisor and the ERO LGBTI Field Liaison. The PSA Compliance Manager further indicated if during intake, a detainee self-identifies as being a transgender or intersex detainee, the detainee would be initially classified and housed in the medical unit until the committee can make placement decisions and the effects the placement may have on the detainee's health and safety. However, the PSA Compliance Manager further indicated the TCCC will meet with the transgender or intersex detainee within 72 hours to obtain the detainee's preferences regarding housing, searches, and other matters and to gather information necessary to determine the detainee's preference in housing while housed at ICAF. In addition, the PSA Compliance Manager confirmed transgender or intersex detainees would be reassessed twice a year to review any threats to safety experienced by the detainee and transgender and intersex detainees are given the opportunity to shower separately from other detainees by allowing the transgender/intersex detainee to shower during count time. During the on-site audit there were no transgender or intersex detainees housed at the facility.

**Corrective Action:**

The facility is not in compliance with subsection (a) of the standard. In an interview with the PSA Compliance Manager, it was indicated information from the initial risk assessment is added to the OMS which is designed to track the detainee who has been identified as being vulnerable to sexual abuse by placing a V Code into the system or a P Code to track detainees identified to be sexual aggressors. However, during interviews the PSA Compliance Manager and the Intake Processing Supervisor it was confirmed neither staff could articulate how the facility would utilize the information learned from the initial assessment to inform assignment of detainees to initial housing. The Auditor reviewed 20 detainee files and confirmed an assessment had been completed for each detainee; however, 2 of the files indicated the assessment had been completed two days after the detainee arrived at the facility and 1 detainee file did not include the date the initial risk assessment; and therefore, the

Auditor could not confirm the information gathered from the initial risk assessment was utilized in determining assignment of initial housing To become compliant the facility must submit documentation that confirms all applicable staff, to include Intake, Classification, and the PSA Compliance Manager have been trained on the standard's requirement to utilize the information gained from the initial risk assessment to inform assignment to initial housing. In addition, the facility must submit 10 detainee files to confirm the facility utilized the information gained from the initial risk assessment to inform assignment to initial housing.

**§115.43 - Protective Custody**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d)(e): ICAF policy ICAF-DO-06 states, "FDC has policies and procedures in accordance with the 2011 ICE PBNDS that govern the management of the facility's administrative segregation unit. These procedures have been developed in consultation with ICE/ERO Field Office Director and document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault." ICAF policy ICAF-DO-06 further states, "Use of administrative segregation by FDC to protect detainees vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort" and "FDC shall only assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days." In addition, ICAF policy ICAF-DO-06 states, "In the event FDC places vulnerable detainees in administrative segregation for Protective Custody, the facility shall provide these detainees access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable." ICAF policy ICAF-DO-06 further states, "FDC has written policies and procedures which mandate for the regular review of all vulnerable detainees placed in administrative segregation for their protection, as follows: a) The Chief of Security shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted; b) The Chief of Security shall conduct, at a minimum, an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter; and the Director of Detention, Deputy Director of Operations, or the Chief of Security shall notify the ICE Field Office Director no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault." The Auditor reviewed a memorandum to the file which states, "During the audit period under inspection, the Farmville Detention Center has not had to place a detainee in administrative segregation on the criteria of being vulnerable for sexual abuse victimization or because the detainee was at risk as a potential sexual aggressor." An interview with the PSA Compliance Manager and Auditor observations confirmed the AS Unit includes four dedicated cells utilized for PC. The PSA Compliance Manager further indicated if a detainee vulnerable to sexual abuse is placed in PC he would have access to programs, visitation, counsel, and any other services available to the general population. Interviews with the facility Director and the PSA Compliance Manager indicated that a detainee vulnerable to sexual abuse would only be placed into a PC cell located in the AS unit as a last resort and the placement would not exceed 30 days. The facility Director and the PSA Compliance Manager further indicated prior to placing a detainee in PC notification would immediately be made to the FOD, and all reviews would be conducted per facility policy and documented on the "Administrative Segregation Housing Review" form. In addition, in interviews with the facility Director and the PSA Compliance Manager it was confirmed there has not been a detainee placed PC based on being vulnerable to sexual abuse during the audit period. During the on-site audit the Auditor through direct observation confirmed there were no detainees in PC due to being vulnerable to sexual abuse.

**Corrective Action:**

No corrective action needed.

**§115.51 - Detainee Reporting**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "FDC has policies and procedures that ensure detainees have multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. These procedures also provide instructions on how detainees may contact their consular official, the DHS Office of the Inspector General, the Joint Intake Center, and other designated entities outlined in the 2011 ICE PBNDS and DHS PREA Standards, to confidentially and, if desired, anonymously, report these incidents. Under FDC's Sexual Abuse and Assault Prevention and Intervention Program detainees who are victims of sexual abuse or assault also possess the option to report an incident or situation to the program coordinator, the mental health counselor, or any staff member, either verbally or in writing. The name and contact information for the Sexual Abuse and Assault Prevention and Intervention Program Coordinator is posted in all housing areas and Processing. Additionally, the detainee handbook, SAAPI awareness notice posted in all housing units, the new arrival orientation videos, and the back of detainee's badges educates and provides multiple pathways to report incidents of sexual harassment, abuse, and assault. FDC also provides detainees a way to report sexual abuse to a public or private entity that is not part of or affiliated with the facility, and that is able to receive and immediately forward detainee reports of sexual abuse to facility officials, allowing the detainee to remain anonymous upon request. The YWCA Sexual Assault Response Program is the designated private entity the facility has a cooperative agreement with to fulfill the obligations of this component of the DHS PREA Standards." ICAF policy ICAF-DO-06 further states, "FDC has established procedure which includes provisions for any staff member to accept reports of sexual abuse or assault from detainees or any individual or entity whether verbally, in writing, anonymously, and from third parties and to promptly document such reports. Examples of reporting under the above circumstance with specific emphasis on third party reporting include the following: a) Incoming telephone calls made to the facility, which are recorded; b) Detainee visitors, attorneys, legal representatives, counselor officials, or CAIR who make a report during their visit; c) Incoming mail addressed to the facility. FDC's website provides the public with this contact information and additionally educates the public with information on how to report sexual abuse on behalf of a detainee, including the facility's protocols pertaining to responding to allegations of sexual abuse, http://ica-Farmville.com/?page_id=159; and d) Reporting from YWCA Sexual Assault Response Program." An interview with the PSA Compliance Manager indicated detainees are provided multiple ways to report an allegation, including but not limited to the DHS OIG which is not a part of the Agency. During the on-site audit, the Auditor observed information posted in all detainee housing units to include how to contact their consular official, the DHS OIG, DRIL, and the designated facility PREA Hotline, and the YWCA flyer to confidentially and if desired anonymously report an incident of sexual abuse. In addition, the Auditor observed the back of the detainee's ID cards, the detainee "Orientation PowerPoint", and the facility Detainee Handbook and confirmed the detainee is provided contact numbers for DRIL, DHS OIG, ICE/OPR Joint Intake Center, YWCA, and the National Suicide Prevention Hotline. During the on-site audit the Auditor tested the phone numbers utilizing the detainee telephones and confirmed they were in good working order. In addition, the Auditor reported a mock allegation to the facility PREA Hotline. The PSA Compliance Manager confirmed receipt of the mock allegations and provided the Auditor with an email confirming he received the mock report; however, the PSA Compliance Manager indicated the email does not include the reason the detainee is calling the PREA hotline due to the information being restricted by the Agency. Interviews with 20 detainees, confirmed the detainees interviewed could articulate at least three ways to report an allegation at the facility.

**Recommendations:** The Auditor recommends the email received confirming a detainee reported an allegation of sexual abuse utilizing the facility PREA Hotline include the reason for utilizing the line.

**Corrective Action:**

No corrective action needed.

**§115.52 - Grievances**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d)(e)(f): ICAF policy ICAF-DO-06 states, "FDC permits a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. Likewise, FDC shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse." ICAF policy ICAF-DO-06 further states, "FDC staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment" and "in accordance with the facility's Grievance Policy, FDC shall issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. In addition, ICAF policy ICAF-DO-06 states, "FDC shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the ICE Field Office Director at the end of the grievance process" and "to prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties." ICAF policy ICAF-DO-23, Grievance Policy, states, "All Farmville Detention Center staff will be trained to respond to time sensitive emergency grievances in an expeditious matter. When a staff member determines that a detainee is raising an issue that involves an immediate threat to health, safety or welfare, emergency grievance procedures will apply. Translation services will be available to those who need it. Emergency grievances may be brought by a detainee to a designated grievance officer (GO) or directly to the Director or their designee. If these personnel are not available, the shift commander may be informed of the complaint. A report of the grievance, including the nature of the complaint, the name of the detainee and the action taken to resolve the issue, will be prepared in written form and forwarded to the Director or designee. Shift Commanders will consider urgent requests for Law Library usage and access to counsel as emergency grievances and will follow the procedures contained herein for resolving emergency grievances." ICAF policy ICAF-DO-23 further states, "All emergency grievance reports, to include the circumstances of the grievance and the resolution, will be placed in the detainee's detention file and documented in the facility's grievance log" and "medical emergencies will be brought to the immediate attention of proper medical personnel for further assessment." In addition, ICAF policy ICAF-DO-23 states, "The detainee shall have the option to file an appeal if the detainee is dissatisfied with a GAB decision and shall be informed of that option. b) The director, in some cases in conjunction with the ICE/ERO field office director, shall review the grievance appeal and issue a decision within five days of receipt of the appeal. A written decision shall be written in all cases and forwarded to the field office director." ICAF policy ICAF-DO-23 further states, "The facility shall send all grievances related to sexual abuse and assault and the facilities decisions with respect to such grievances to the Field Office Director at the end of the grievance process" and "to prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members or legal representatives. Staff will take reasonable steps to expedite requests for assistance from these other parties." An interview with the facility GO, indicated grievance forms and locked grievance boxes are in all housing units and are picked up daily. The GO further indicated no time limits are imposed on grievances alleging sexual abuse and detainees can request the assistance of another detainee, staff, family, legal representative, or any other person to prepare a grievance alleging sexual abuse. In addition, the GO indicated all PREA grievances are considered emergency grievances and if an emergency sexual abuse grievance is received, staff would immediately ensure the detainee is safe and medical would be notified to conduct an assessment. In addition, the GO indicated that all PREA related grievances are maintained by the facility PSA Compliance Manager and a copy of the grievance and the facility's decision in respect to the grievance is forwarded to the ICE FOD. The Auditor reviewed one sexual abuse allegation investigation and confirmed the allegation was initially made utilizing the grievance system; however, the allegation was ultimately accepted through a report made through the DRIL.

**Corrective Action:**

No corrective action needed.

**§115.53 - Detainee access to outside confidential support services**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d): ICAF policy ICAF-DO-06 states, "FDC has a Cooperative Agreement (See Appendix C) with the YWCA Sexual Assault Response Program which provides expertise and support services for immigrant victims of crime including 24-hour crisis intervention, victim advocacy, group and individual counseling, legal assistance, and many other support services for detainee victims of sexual abuse. In accordance with the 2011 ICE PBNDS, FDC shall also attempt to make these victim services available for any detainee identified as having experienced sexual victimization prior to entering DHS custody or if a detainee experienced sexual victimization elsewhere in ICE custody. The emotional support services provided by the YWCA Sexual Assault Response Program are confidential and shall not be used to the determinant of any detainee seeking or requesting such access to this organization." The Auditor reviewed an open ended, with the clause that either party can terminate the agreement with a 30-day written notice, Cooperative Agreement between YWCA Sexual Assault Response Program and ICAF, dated February 17, 2023, and confirmed the Cooperative Agreement outlines the roles and responsibilities of the YMCA to include, but are not limited to, providing crisis intervention and/or referrals, providing follow-up services to sexual violence victims detained/incarcerated at ICAF, and providing accompaniment services (e.g., accompaniment to forensic sexual assault exams and criminal and/or civil legal proceedings, protective order hearings, preliminary hearings, and other relevant legal proceedings related to sexual victimization). During the on-site audit, the Auditor observed the YWCA flyer posted in the housing units. The flyer provides the detainees a phone number and a mailing address to contact a victim advocate. Utilizing the detainee phone system and posted instructions on how to complete an anonymous call, the Auditor tested the contact number for the YWCA; however, the Auditor was unable to complete the call. The PSA Compliance Manager immediately began to investigate the matter and the Auditor was able to complete the call during the on-site audit. Prior to the YWCA answering, the phone system does inform the detainee that the call is unmonitored and unrecorded and is confidential. The Auditor conducted an interview with a YWCA victim advocate who confirmed the services provided to the detainees housed at ICAF. Interviews with 20 detainees, confirmed they were aware of the services provided by YWCA and how to contact the organization to utilize the services provided.

**Corrective Action:**

No corrective action needed.

**§115.54 - Third-party reporting**

**Outcome:** Meets Standard

**Notes:**

ICAF policy ICAF-DO-06 states, "FDC has established procedure which includes provisions for any staff member to accept reports of sexual abuse or assault from detainees or any individual or entity whether verbally, in writing, anonymously, and from third parties and to promptly document such reports. Examples of reporting under the above circumstance with specific emphasis on third party reporting include the following: a) Incoming telephone calls made to the facility, which are recorded; b) Detainee visitors, attorneys, legal representatives, counselor officials, or CAIR who make a report during their visit; c) Incoming mail addressed to the facility. FDC's website provides the public with this contact information and additionally educates the public with information on how to report sexual abuse on behalf of a detainee, including the facility's protocols pertaining to responding to allegations of sexual abuse, http://ica-farmville.com/?page_id=159; and d) Reporting from YWCA Sexual Assault Response Program." The Auditor reviewed the facility website and confirmed information, and instruction, is provided to the public for filing an allegation of sexual abuse on behalf of a detainee to include phone numbers and email addresses for reporting to, DHS OIG, the DRIL, ICE/OPR Joint Intake Center, DHS/ICE/ERO WAS-Richmond Sub-Office, DHS/ICE/ERO WAS-Chantilly, and the YWCA of Central Virginia. The Auditor reviewed the PREA Allegation Spreadsheet and the SAAPI DRIL notification and confirmed the one sexual abuse allegation reported during the auditperiod was reported through the DRIL.

**Corrective Action:**

No corrective action needed.

**§115.61 - Staff and Agency Reporting Duties**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." ICAF policy ICAF-DO-06 states, "FDC requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred at the facility including; a) Retaliation against detainees or staff who reported or participated in an investigation about such an incident; b) Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation; and c) Staff are required to immediately report any of the above specified conditions to their designated supervisor immediately whether the information came verbally, in writing, anonymously, or by third party. FDC has procedures in place where staff can receive third-party reports of sexual abuse at the facility. Likewise, information on reporting sexual abuse on behalf of a detainee is made available to the public and this information can be accessed on the facility's website at http://ica-farmville.com/?page_id=159. d) FDC also authorizes and permits staff to make a report concerning a violation of the facility's Sexual Abuse and Assault Prevention and Intervention policy outside the chain of command if the staff member has a reasonable fear of retaliation or retribution for making the report. The last page of this policy contains contact information on the anonymous reporting hotline operated independently by Lighthouse Services, Inc. Apart from such reporting, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions. If the alleged victim is considered a vulnerable adult under a State or local vulnerable persons statute, FDC shall report the allegation to the local Social Services office under applicable mandatory reporting laws. In the Commonwealth of Virginia mandatory reporting is required for adults 60 years of age or older and incapacitated adults aged 18 or older. FDC shall report any suspected sexual abuse, neglect, or exploitation of elders or incapacitated adults and shall document that these notifications were made." Interviews with six security line staff confirmed they were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Interviews with six security line staff further confirmed they are aware of their ability to make a report outside the chain of command; however, the security line staff could not remember the name of the agency. During the on-site audit the Auditor observed through direct observation Lighthouse Services is a line provided to staff for making a report anonymously or outside the chain of command. In addition, the Auditor confirmed through direct observation the facility provides the Lighthouse Services contact information on the back of the employee ID cards. Interviews with the facility Director and the PSA Compliance Manager indicated if there was an allegation of sexual abuse reported involving a vulnerable adult detainee, a report would be made to the local social services office and ICE. In addition, interviews with the facility Director and the SDDO confirmed that all policy and procedures have been reviewed and approved by the Agency.

**Recommendation (a):** The Auditor recommends that the facility issue a memorandum to all staff reminding staff of their ability to report an allegation of sexual abuse outside the chain of command utilizing the contact information for Lighthouse Services located on the back of the employee ID card.

**Corrective Action:**

No corrective action needed.

**§115.62 - Protection Duties**

**Outcome:** Does Not Meet Standard

**Notes:**

ICAF policy ICAF-DO-06 states, "If a FDC staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." Interviews with the facility Director, the PSA Compliance Manager, and six security line staff confirmed if they become aware a detainee is at substantial risk of sexual abuse their first response would be to take immediate action to protect the detainee. The Auditor reviewed one sexual abuse allegation investigation file which included contract staff-on-detainee and confirmed, although ICE accepted the allegation, the facility initially did not consider the allegation a PREA; and therefore, did not take action immediate action to protect the detainee.

**Corrective Action:**

The facility does not meet the standard. The Auditor reviewed one sexual abuse allegation investigation file which included contract staff-on-detainee and confirmed, although ICE accepted the allegation, the facility initially did not consider the allegation a PREA; and therefore, did not take immediate action to protect the detainee. To become compliant the facility must train all security line staff and the PSA Compliance Manager on the standard's requirement to take immediate action to protect the detainee from a risk of sexual abuse. In addition, if applicable the facility must submit all sexual abuse allegation investigation files that occur during the CAP period.

**§115.63 - Reporting to other Confinement Facilities**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d): ICAF policy ICAF-DO-06 policy states, "Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the Director shall notify the ICE Field Office and the administrator of the facility where the alleged abuse occurred. This notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation and the Director of Detention shall document that it, he has provided such notification. If FDC receives notification from another confinement facility that a detainee claims sexual abuse while detained at FDC, an investigation shall be conducted in accordance with the provisions and stipulations of the DHS PREA Standards and the incident shall be reported to the ICE Field Office Director." An interview with the facility Director indicated if the facility received notification from another facility that a detainee alleged, he was sexually abused while housed at ICAF, the allegation would immediately be referred to the PSA Compliance Manager and facility Investigators to ensure an investigation is completed and a notification would be made to the ICE FOD. The facility Director further indicated, if an allegation was received that a detainee was sexually abused while confined in another facility, he would notify the head of the facility within 72 hours; however, the notification is usually immediate. In addition, the facility Director indicated the notification would be made by phone and followed up with an email for documentation purposes. The Auditor reviewed an email sent by the facility Director to another facility administrator in April of 2023 and confirmed the email was sent within 72 hours and notified the other facility administrator a detainee at ICAF reported he had been sexually abused while housed at his/her facility.

**Corrective Action:**

No corrective action needed.

**§115.64 - Responder Duties**

**Outcome:** Meets Standard

**Notes:**

(a)(b): ICAF policy ICAF-DO-06 states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or his or her Shift Commander or designated Supervisor, is required to: a) Separate the alleged victim and abuser; b) Preserve and protect, 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; and d) If the sexual abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. 5. If the first staff responder is not a security staff member such as a contractor or volunteer, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." The Auditor reviewed a memorandum to the file which states, "During the audit period under inspection, the Farmville Detention Center has not had an instance where a detainee made a sexual abuse report to a security staff member allowing for the facility to document and demonstrate first responder duty actions." During the on-site audit, the Auditor observed the back of the facility staff ID cards and confirmed the ID cards include first responder responsibilities during an incident of sexual abuse to include separating the alleged victim and abuser; maintaining constant supervision with victim; preserve and protect the crime scene; advise the victim not to take any actions that could destroy physical evidence; ensure the alleged abuser does not take any actions that could destroy physical evidence." In an interview the PSA Compliance Manager indicated all staff are provided refresher training that covers first responder duties on an annual basis; however, during interviews with six security line staff it was confirmed they would place both the detainee victim and the alleged abuser into dry cells and would not allow either to take any action that would destroy physical evidence. While the Auditor was on-site, the facility Director immediately issued a training memorandum to all staff, reminding them of their duties as first responder duties, to include requesting the victim not to take any action that would destroy evidence. The memorandum was uploaded to the facility Power DMS (Document Management System). Once uploaded, staff are required to review and acknowledge by signature, that they have reviewed the document. Prior to leaving the facility, the Auditor observed that ten security line staff had viewed and acknowledge that had read the memorandum.

**Recommendation:** The Auditor recommends that the facility update their first responder duty cards that state, "advise the victim not to take any actions that could destroy physical evidence" to correspond with ICAF policy ICAF-DO-06 which states, "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."

**Corrective Action:**

No corrective action needed.

**§115.65 - Coordinated Response**

**Outcome:** Does Not Meet Standard

**Notes:**

(a)(b): ICAF policy ICAF-DO-06 states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or his or her Shift Commander or designated Supervisor, is required to: a) Separate the alleged victim and abuser; b) Preserve and protect, 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; and d) If the sexual abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder is not a security staff member such as a contractor or volunteer, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." ICAF policy ICAF-DO-06 further states, "FDC's coordinated multidisciplinary protocol and institutional plan for responding to detainee sexual abuse or assault is clearly detailed in this policy describing the procedures that will be taken by staff first responders, Shift Commanders or Assistant Shift Commanders, Sozo medical staff and mental health practitioners, facility investigators, facility leadership, and outside organizations which the facility have Cooperative Agreements and Memorandums of Understanding with (aka: SART—Sexual Assault Response Team)." An interview with the PSA Compliance Manager indicated that ICAF policy ICAF-DO-06 is the facility's coordinated response plan to coordinate the actions taken by first responders, investigators, medical and mental health, and the facility leadership. The Auditor reviewed the policy in its entirety and confirmed the plan coordinates the action taken by security and non-security first responders, medical and mental health practitioners, facility investigators, and facility leadership in response to an incident of sexual abuse. Interviews with the HSA, a mental health LPC, and the PSA Compliance Manager/Investigator confirmed they were knowledgeable of their responsibilities as a first responder; however, interviews with six security line staff, confirmed staff interviewed would place both the victim and the alleged abuse into dry cells and would not allow either to take any action that would destroy physical evidence. While the Auditor was on-site, the facility Director immediately issued a training memorandum to all staff, reminding them of their duties as first responder duties, to include requesting the victim not to take any action that would destroy evidence. The memorandum was uploaded to the facility Power DMS Once uploaded, staff are required to review and acknowledge by signature, that they have reviewed the document. Prior to leaving the facility, the Auditor observed that ten security line staff had viewed and acknowledge that had read the memorandum.

**Recommendation (a):** The Auditor recommends that the facility update their first responder duty cards that state, "advise the victim not to take any actions that could destroy physical evidence" to correspond with ICAF policy ICAF-DO-06 which states, "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."

(c)(d): ICAF policy ICAF-DO-06 states, "If a detainee victim of sexual abuse is transferred between DHS immigration detention facilities, FDC shall, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the incident and the detainee victim's potential need for medical or social services. If a detainee victim is transferred from FDC to a non-DHS facility, the facility, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. If the receiving facility is unknown to FDC, the Director of Detention shall notify the Field Office Director, so that he or she can notify the receiving facility." Interviews with the facility Director and the HSA indicated that the facility would provide information regarding the victim's potential need for medical and mental health services. If the detainee is transferred to a non-DHS facility, the medical staff would obtain the detainee's consent prior to providing the information to the receiving facility.

**Corrective Action:**

The facility is not in compliance with subsections (c) and (d) of the standard. The Auditor reviewed ICAF policy ICAF-DO-06 which serves as the facility coordinated response plan and confirmed the coordinated response plan requires "if a detainee victim of sexual abuse is transferred between DHS immigration detention facilities, FDC shall, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the

incident and the detainee victim's potential need for medical or social services. If a detainee victim is transferred from FDC to a non-DHS facility, the facility, as permitted by law and in consultation with the ICE Field Office, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." However, the standard requires the facility response plan includes the verbiage, "If a victim of sexual abuse is transferred between facilities, covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." To become compliant, the facility shall revise ICAF-DO-06 to include "If a victim of sexual abuse is transferred between facilities, covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "If a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." Once ICAF policy ICAF-DO-06 is updated facility must provide documentation that confirms all applicable staff, including medical, have been trained on the updated policy. In addition, if applicable the facility must provide the Auditor with any detainee sexual abuse allegation investigation files, and the corresponding medical records, of any detainee transferred to a facility not covered by paragraph (c) of this section that occurred during the CAP period.

**§115.66 - Protection of detainees from contact with alleged abusers**

**Outcome:** Does Not Meet Standard

**Notes:**

ICAF policy ICAF-DO-06 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. FDC shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions of facility policies." Interviews with the facility Director and the PSA Compliance Manager indicated that if a staff member, contractor, or volunteer is alleged to have been involved in an incident of sexual abuse the staff member, contractor, or volunteer would be removed from any position having detainee contact until the conclusion of the investigation. The Auditor reviewed one investigative file and could not confirm the staff member involved in the allegation had been removed from detainee contact until the completion of the investigation.

**Corrective Action:**

The facility is not in compliance with the standard. The Auditor reviewed one investigative file and could not confirm the staff member involved in the allegation had been removed from detainee contact until the completion of the investigation. To become compliant, the facility must submit documentation that confirms all applicable staff, including the PSA Compliance Manager has received training on the standard's requirement to remove staff, contractors, and volunteers suspected of perpetrating sexual abuse from all duties requiring detainee contact pending the outcome of an investigation. In addition, if applicable, the facility must provide any sexual abuse allegation investigation files that include staff, contractor or volunteers that have occurred during the CAP period.

**§115.67 - Agency protection against retaliation**

**Outcome:** Does Not Meet Standard

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "Monitor to ensure that any staff, contractor, or volunteer does not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. a) For at least 90 days following a report of sexual abuse, FDC shall monitor to see if there are facts

that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. This procedure for monitoring applies to criminal investigations conducted by the Farmville Police Department and facility conducted administrative investigations. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. b) The PSA Compliance Manager, Facility Chaplains, and Mental Health staff are the primary individuals assigned to conduct monitoring for retaliation and shall document compliance with this provision of the DHS PREA Standards. When monitoring for retaliation, FDC shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigation. Emotional support services for detainees and staff are contingent on individuals consenting to such services. Additional monitoring also includes periodic interviews with detainees or staff, reviewing detainee disciplinary reports, program changes, or negative performance reviews or reassignment of staff." In an interview with the PSA Compliance Manager, it was indicated he and the facility Chaplain are responsible for retaliation monitoring of detainee victims of sexual abuse and HR staff is responsible to staff. The PSA Compliance Manager further indicated a detainee victim of sexual abuse would be monitored for retaliation for up to 90 days and the review would include reviewing the detainee's housing, disciplinary record, or any program changes, that may have occurred as a result of retaliation. An interview with the HRM indicated staff who report or cooperate with an allegation of sexual abuse investigation would be monitored for retaliation to include negative performance reviews or reassignment of the staff member's assigned post. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the facility had not monitored the victim detainee for retaliation.

**Corrective Action:**

The Agency and facility are not in compliance with subsection (c) of the standard. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the Agency and the facility had not conducted retaliation monitoring of the detainee victim. To become compliant, the facility must submit documentation that confirms all applicable staff, including the PSA Compliance Manager, has received training on the standard's requirement to monitor for at least 90 days following an incident of sexual abuse monitor to ensure any staff, contractor, or volunteer does not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. In addition, if applicable, the facility must provide any sexual abuse allegation investigation files, and the corresponding monitoring documentation, that has occurred during the CAP period.

**§115.68 - Post-allegation protective custody**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d): ICAF policy ICAF-DO-06 states, "FDC shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible (e.g., protective custody). Detainee victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. FDC shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours." Interviews with the facility Director and the PSA Compliance Manager indicated a detainee victim of sexual abuse would only be placed in PC cells located in the AS unit as a last resort, or at the request of the victim detainee, until alternative arrangements could be made; however, the placement would not exceed five days. The facility Director further indicated any time a detainee is placed into PC due to an incident of sexual abuse the ICE FOD would be notified immediately. An interview with the PSA Compliance Manager indicated prior to the detainee victim's release from PC into general population the facility would conduct a re-assessment taking into consideration any increased vulnerability of the

detainee as a result of the sexual abuse. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the detainee had not been placed into protective custody due to being a victim of sexual abuse.

**Corrective Action:**

No corrective action needed.

**§115.71 - Criminal and administrative investigations**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(e)(f): ICAF policy ICAF-DO-06 states, "All internal administrative investigations into alleged sexual abuse shall be prompt, thorough, objective, and conducted by specially trained, qualified investigators. Furthermore, internal administrative investigations procedures shall consider the following stipulations if present or applicable: a) Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; b) Interviewing alleged victims, suspected perpetrators, and witnesses; c) Reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; d) An 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; e) A concerted effort to determine whether actions or failures to." ICAF policy ICAF-DO-06 further states, "FDC shall suspend the internal administrative investigation until the conclusion of the Farmville Police Department's criminal investigation as to not compromise or interfere with their investigation. At all stages of the investigation process, FDC will maintain coordination and communication with the ICE Office of Professional Responsibility and the Farmville Police Department. Regardless of whether the Farmville Police Department's criminal investigation into an allegation of sexual abuse or assault is substantiated, unsubstantiated, or unfounded FDC shall conduct an internal administrative investigation and request copies of all relevant investigative reports and documents from this law enforcement agency. In addition, ICAF policy ICAF-DO-06 states, "a) All documentation collected and obtained from the criminal investigation by the Farmville Police Department and internal administrative investigation by FDC shall be maintained for at least five years, which includes all reports and referrals on allegations of sexual abuse. b) FDC shall retain all reports and documentation on the alleged abuser while he or she is detained at FDC or employed by FDC, plus five years" and "FDC administrative investigations shall be conducted after consultation with ICE and for any incident referred to the Farmville Police Department. The Farmville Police Department will also be notified that the facility intends to conduct an internal administrative investigation." ICAF policy ICAF-DO-06 further states, "The Director of Detention shall review and approve the Farmville Detention Center's procedures for coordination of internal administrative investigations with the Farmville Police Department to ensure non-interference with any criminal investigation" and "furthermore, the Director of Detention will ensure that the departure of the alleged abuser or victim from employment or custodial control of FDC shall not provide a basis for terminating an investigation." An interview with the PSA Compliance Manager/Investigator indicated the facility will complete an administrative investigation on all allegations of sexual abuse after consultation with the FPD. The PSA Compliance Manager/Investigator further indicated the facility will cooperate with the FPD and will remain informed of the status of the investigation through continuous contact. In addition, the PSA Compliance Manager/Investigator further indicated an administrative investigation will be completed regardless of whether the alleged abuser or victim has left the employment or control of the facility or Agency. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the allegation of sexual abuse was not criminal in nature and had been completed promptly, thoroughly, and objectively by a specially trained and qualified facility investigator. In addition, the Auditor reviewed the training records of the Agency investigator noted on the PREA Allegation Spreadsheet and confirmed the named Agency investigator has been specially trained as required by subsection (a) of the standard.

**Corrective Action:**

No corrective action needed.

**§115.72 - Evidentiary standard for administrative investigations**

**Outcome:** Meets Standard

**Notes:**

Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse. Additionally, the ICE OPR Investigations Incidents of Sexual Abuse and Assault training required for investigators includes the evidentiary standard for administrative investigations." ICAF policy ICAF-DO-06 states, "When conducting an administrative investigation into an incident of sexual harassment, abuse, or assault, FDC shall impose no standard higher than a preponderance of evidence criteria when determining whether allegations of sexual abuse are substantiated." An interview with the PSA Compliance Manager/Investigator indicated when determining whether allegations of sexual abuse are substantiated the facility will not impose a standard higher than a preponderance of evidence.

**Corrective Action:**

No corrective action needed.

**§115.73 - Reporting to detainees**

**Outcome:** Meets the Standard

**Notes:**

ICAF policy ICAF-DO-06 states, "Detainees who have reported allegations of sexual abuse and are still detained at FDC shall be notified about the results of the investigation and any responsive action taken by the facility following the investigation." An interview with the PSA Compliance Manager, indicated detainee victims of sexual abuse would be notified of the result of the investigation and any responsive action that is taken. The Auditor reviewed one sexual abuse allegation investigation and could not confirm the detainee was notified as to the result of the investigation or any responsive action taken. In addition, the Auditor submitted the ICE "Notification to Detainee of PREA Investigation Results" form to the TL and received a copy of the notification letter confirming the victim detainee has received the results of the investigation.

**Corrective Action:**

No corrective action needed.

**§115.76 - Disciplinary sanctions for staff**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d): ICAF policy ICAF-DO-06 states, "Staff shall be subject to disciplinary or adverse action up to and including removal from their position for substantiated allegations of sexual abuse or for violating FDC's Sexual Abuse and Assault Prevention and Intervention policy or Standards of Conduct policy. The Director of Detention, Chief of Security, and Human Resource Manager shall review and approve facility policies and procedures regarding disciplinary or adverse actions for staff and shall ensure that the facility policy and procedures specify disciplinary or adverse actions for staff, up to and including removal from their position, when there is a substantiated allegation of sexual abuse, or when there has been a violation of facility's sexual abuse rules, policies, or standards. Removal from their position is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer. FDC shall report all removals or resignations in lieu of removal for violations of the facility sexual abuse policies to appropriate law enforcement agencies unless the activity was clearly not criminal. FDC shall make reasonable efforts to report removals or resignations in lieu of removal for violations of the facility sexual abuse policies to any relevant licensing bodies, to the extent known." Interviews with the facility Director and the HRM indicated staff are subject to disciplinary action, which can include, removal from detainee contact pending an investigation, administrative leave or removal from their position and Federal service, depending on the severity of the allegation. Interviews with the facility Director and the HRM further indicated if there is a substantiated allegation of sexual abuse, the staff member

would be terminated and would be reported to the FPD and any licensing bodies. In additions, interviews with the facility Director and HRM indicated ICAF has not had a substantiated allegation involving a staff member during the reporting period. A review of ICAF policy ICAF-DO-06 confirms it does not include the verbiage, "Removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." However, as termination is greater than removal from Federal Service, the Auditor finds ICAF policy ICAF-DO-06 in substantial compliance with subsection (b) of the standard. Interviews with six security line staff indicated they were aware termination is the presumptive disciplinary sanction for staff who violate Agency or facility PREA policies. A review of one sexual abuse allegation investigation file confirmed there were no substantiated allegations of sexual abuse involving staff or contractor staff sexual misconduct to demonstrate termination, resignation, or other disciplinary actions taken by the facility. A review of a memorandum to the file and interviews with the facility Director and SDDO confirmed ICAF policy ICAF-DO-06 has been reviewed and approved by the Agency.

**Corrective Action:**

No corrective action needed.

**§115.77 - Corrective action for contractors and volunteers**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "Any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees. FDC shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. Such incidents shall also be reported to law enforcement agencies unless the activity was clearly not criminal. Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. FDC shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions of facility policies." Interviews with the facility Director and the HRM indicated a contractor or volunteer suspected of engaging or attempting to engage in sexual abuse with a detainee or violating other provisions of the facility sexual abuse policy would be removed from the facility, and any detainee contact, until an allegation of sexual abuse investigation had been completed. Interviews with the facility Director and the HRM further indicated the facility would notify the FPD and any licensing body. An interview with a facility contractor confirmed she was aware of the sanctions for violating the facility sexual abuse policy. The Auditor reviewed samples of a template letter the facility would use to notify the licensing bodies of the allegation and a template to notify the contractor and/or volunteer of their removal from the facility. In addition, the Auditor reviewed a memorandum which indicated the facility has not had a contractor or volunteer who has been removed from the facility due to an incident of sexual abuse during the audit period. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the allegation did not involve an "other" contractor or a volunteer.

**Corrective Action:**

No corrective action needed.

**§115.78 - Disciplinary sanctions for detainees**

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c)(d)(e)(f): ICAF policy ICAF-DO-06 states, "FDC shall subject a detainee to disciplinary sanctions pursuant to a formal disciplinary process outlined in the 2011 ICE PBNDS following an administrative or criminal finding that the detainee engaged in sexual abuse. At all steps in the disciplinary process any sanctions imposed upon a detainee perpetrator shall be commensurate with the severity of the committed prohibited act and with the intent to encourage the detainee to conform with rules and regulations in the future. Under the

provisions of the 2011 ICE PBNDS, FDC has enacted a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures. FDC's disciplinary process shall consider whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. FDC shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." Interviews with the facility Director and the PSA Compliance Manager indicated the facility has a disciplinary system that includes reviews, appeals, and documentation procedures. Interviews with the facility Director and PSA Compliance Manager further indicated the disciplinary process considers whether the detainee's mental disabilities or mental illness contributed to his behavior when determining the sanctions imposed. In addition, interviews with the facility Director and the PSA Compliance Manager indicated detainees are subject to disciplinary sanction pursuant to the formal disciplinary process for an administrative or criminal finding that the detainee engaged in sexual abuse; however, detainees are not disciplined for reports made in good faith based on a reasonable belief that the alleged conduct had occurred. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the detainee victim was not disciplined for reporting the allegation.

**Corrective Action:**

No corrective action needed.

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

**Outcome:** Meets Standard

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "In accordance with the SOP's on Admission and Release and Custody Classification System: each new arrival will be kept separate from the general population until he or she is classified and may be housed accordingly. Detainees who have been identified as being at risk for sexual victimization shall be immediately referred to a qualified Mental Health professional for further assessment, treatment and/or counseling." ICAF policy ICAF-DO-06 further states, "When a medical referral is initiated, the detainee shall receive a health evaluation no later than two working days from the date of the assessment. Likewise, when a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." An interview with the Intake Processing Supervisor indicated if the initial risk assessment indicates a detainee has experienced prior sexual victimization or perpetrated sexual abuse, Intake staff will complete a referral for a medical and mental health follow-up evaluation. An interview with the facility HSA and a mental health LPC indicated if a medical or mental health referral is received, medical staff will initiate a follow-up with the detainee for a health evaluation within two days and mental health would usually initiate a follow-up mental health evaluation immediately: however, always within 72 hours. The Auditor reviewed 20 randomly selected detainee files and confirmed none of the detainees had reported previous sexual abuse or identified as having perpetrated sexual abuse. However, during the on-site audit the HSA provided the Auditor with an initial risk assessment, and corresponding referrals to medical and mental health, of a detainee who had identified as having perpetrated sexual abuse. The Auditor reviewed the initial risk assessment, and corresponding referrals, and confirmed the referral was initiated during the detainee's intake process and both medical and mental health had attempted a follow-up within the required timeframes; however, during the follow-up the detainee signed a refusal for treatment.

**Corrective Action:**

No corrective action needed.

**§115.82 - Access to emergency medical and mental health services**

**Outcome:** Does Not Meet Standard

**Notes:**

(a)(b): ICAF policy ICAF-DO-06 states, "Detainee victims of sexual abuse shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted prophylaxis, in accordance with professionally accepted standards of care. Treatment services, including any emergency medical treatment services, shall be provided to detainee victims without financial cost and regardless of whether the detainee victim names the abuser or cooperates with any investigation arising out of the incident." An interview with the HSA indicated a detainee victim of sexual abuse would be triaged at ICAF and then transported to Lynchburg General Hospital for emergency medical treatment including a SANE exam. A victim would be offered emergency contraceptives and sexually transmitted infections prophylaxis. During the on-site audit, the Auditor spoke with a victim advocate from the YMCA and confirmed SANE exams are conducted at the Lynchburg General Hospital and a YWCA advocate would accompany a victim detainee to the hospital and stay with him during the SANE exam to provide emotional support and crisis intervention. In addition, in an interview with a victim advocate from the YWCA it was further confirmed emergency services would be provided to detainee victims of sexual abuse to sexually transmitted infections prophylaxis, without financial cost, and whether the victim names the abuser or cooperates with an investigation. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the detainee victim had not been provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required by the standard. The facility does not house female detainees.

**Corrective Action:**

The facility is not compliant with section (a) of the standard. The Auditor reviewed one investigative file and confirmed the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required in the standard. To become compliant the facility must develop a protocol that requires staff to take an alleged victim of sexual assault to medical for evaluation after every reported incident of sexual abuse. In addition, the facility must submit documentation that confirms staff have been trained on the implemented protocol. In addition, if applicable, the facility must submit all sexual abuse allegation investigation files and the corresponding medical and mental health records that occur during the audit period.

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

**Outcome:** Does Not Meet Standard

**Notes:**

(a)(b)(c)(d)(e)(f)(g): ICAF policy ICAF-DO-06 states, "FDC in cooperation with Sozo Medical shall offer medical and mental health evaluation services and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention" ICAF policy ICAF-DO-06 further states, "The evaluation and treatment of such victims shall include, as appropriate, follow-up services, crisis intervention, treatment plans, and, when necessary, referrals for continued care following a detainee victim transfer to, or placement in, other facilities, or release from custody." In addition, ICAF policy ICAF-DO-06 states "The medical and mental health services provided to detainee victims of sexual abuse and assault shall be consistent with the services and care offered at the community level." ICAF policy ICAF-DO-06 further states, "In the event FDC houses female detainees, victims of sexually abusive vaginal penetration by a male abuser shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the detainee victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections and HIV testing as medically appropriate. Medical staff shall arrange for appropriate medications and provide routine examination follow-up when necessary. Treatment services, including any emergency medical treatment services, shall be provided to detainee victims without financial cost and regardless of whether the detainee victim names the abuser or cooperates with any investigation arising out of the incident. FDC in cooperation with Sozo Medical shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when

deemed appropriate by mental health practitioners." In an interview with the HSA, indicated, detainee victims of sexual abuse are provided medical and mental health services, free of charge consistent, if not better, than the level of care they would receive in the community. An interview with the HSA further indicated the facility would attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days and offer treatment. An interview with an advocate from the YWCA indicated all detainee victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate, and all services are offered free of charge regardless of if the victim detainee names the abuser or cooperates with the investigation. An interview with a mental health LPC indicated a detainee perpetrator of sexual abuse would receive an evaluation immediately upon learning of a history of sexual abuse and a treatment would be established if the abuser is willing to participate in treatment. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the detainee was eventually provided with information on how to contact the YWCA; however, the detainee was not taken to medical for evaluation as required by subsection (a) of the standard.

**Corrective Action:**

The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed one sexual abuse investigation file and confirmed the detainee was eventually provided with information on how to contact the YWCA: however, the detainee was not taken to medical for evaluation as required by subsection (a) of the standard. To become compliant the facility must train all supervisory staff in the requirement to deliver all alleged victims of sexual abuse to the medical department for evaluation and treatment as appropriate. In addition, if applicable, the facility must submit any sexual abuse allegation investigation files and the corresponding medical and mental health records that occur during the CAP period.

**§115.86 - Sexual abuse incident review**

**Outcome:** Does Not Meet Standard

**Notes:**

(a)(b)(c): ICAF policy ICAF-DO-06 states, "Conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. Staff assigned to the sexual abuse incident review committee shall implement recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the Field Office Director, for transmission to the ICE PSA Coordinator. Additionally, the review committee shall consider: Whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. Whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation." An interview with the PSA Compliance Manager indicated the facility would complete an incident review within 30 days of the conclusion of the investigation which considers if the allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, and whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation. The PSA Compliance Manager further indicated during the reporting period, the facility has not had an allegation of sexual abuse that would require an incident review. The Auditor reviewed the PREA allegation spreadsheet which indicated, an incident review had been conducted on the one sexual abuse allegation investigation reported during the audit period as required by subsection (a) of the standard; however, the facility did not provide documentation to confirm a written report was prepared at the conclusion of the investigation. Therefore, the Auditor could not confirm the incident review considered whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; or whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation. In addition, as no report was submitted to the Auditor the Auditor could not confirm the review and response had been submitted to the

Agency PSA Coordinator. The Auditor reviewed the facility 2022 annual review negative report, and an email from the facility Director confirming the report had been forwarded to the AFOD; however, the Auditor could not confirm the report had been forwarded to the Agency PSA Coordinator.

**Corrective Action:**

The facility is not in compliance with subsections (a), (b) and (c) of the standard. The PSA Compliance Manager further indicated during the reporting period; the facility has not had an allegation of sexual abuse that would require an incident review. The Auditor reviewed the PREA allegation spreadsheet which indicated, an incident review had been conducted on the one sexual abuse allegation investigation reported during the audit period as required by subsection (a) of the standard; however, the facility did not provide documentation to confirm a written report was prepared at the conclusion of the investigation. Therefore, the Auditor could not confirm the incident review considered whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; or whether any staff neglect, or violation of responsibilities and policy may have contributed to an incident or retaliation. In addition, as no report was submitted to the Auditor, the Auditor could not confirm the review and response had been submitted to the Agency PSA Coordinator. The Auditor reviewed the facility 2022 annual review negative report, and an email from the facility Director, confirming the report had been forwarded to the AFOD; however, the Auditor could not confirm the report had been forwarded to the Agency PSA Coordinator. To become compliant, the facility must provide the Auditor with documentation that all staff responsible for conducing incident reviews are trained on the requirements of subsections (a) and (b) of the standard. If applicable, the facility must submit all sexual abuse allegation investigation files and the corresponding incident reviews that occur during the audit period. In addition, the facility must submit documentation to confirm the 2022 annual negative report has been forwarded to the Agency PSA Coordinator.

**§115.87 - Data collection**

**Outcome:** Meets Standard

**Notes:**

(a): CAF policy ICAF-DO-06 states, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary, and/or counseling will be maintained in appropriate files in accordance with applicable FDC policies, and retained in accordance with established schedules." ICAF policy ICAF-DO-06 further states, "FDC shall maintain in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary, and/or counseling in accordance with the DHS PREA Standards, the 2011 ICE PBNDS, and FDC policy." An interview with the facility PSA Compliance Manager indicated the facility maintains all case records associated with allegations of sexual abuse in his office under lock and key. During the on-site audit, the Auditor observed the sexual abuse allegation investigation files and confirmed the files are maintained in a locked cabinet located in the PSA Compliance Manager's Office.

**Corrective Action:**

No corrective action needed.

**§115.201 - Scope of Audit**

**Outcome:** Meets Standard

**Notes:**

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. Interviews with detainees were conducted on-site, in private, and have remained confidential. The Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese,

Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. No detainee, outside entity, or staff correspondence was received prior to the on-site audit, during the on-site audit, or following the on-site audit.

**Corrective Action:**

No corrective action needed.

**AUDITOR CERTIFICATION:**

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

*Robin Bruck* 10/27/2023

**Auditor's Signature & Date**

(b) (6), (b) (7)(C) 10/30/2023

**Program Manager's Signature & Date**

(b) (6), (b) (7)(C) 10/30/2023

**Assistant Program Manager's Signature & Date**