Office of Professional Responsibility

CAP Final Determination Report and PREA Compliance Audit Report

Port Isabel SPC

June 11 - 13, 2024

U.S. Immigration and Customs Enforcement

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

AUDITOR INFORMATION			
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Harlingen		
Field Office Director:	Miguel Vergara		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1717 Zoy Street, Harlingen, TX 78550		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Port Isabel SPC		
Physical address:	27991 Buena Vista Boulevard, Los Fresnos, Texas 78566		
Telephone number:	(956) 547-1700		
Facility type:	Service Processing Center		
PREA Incorporation Date:	3/18/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Assistant Field Office Director (AFOD)
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	956-547-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
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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 Port Isabel met 25 standards, had 0 standards that exceeded, had 1 standard that was non-applicable, and had 15 non-compliant standards. As a result of the facility being out of compliance with 15 standards, the facility entered into a 180-day corrective action period which began on August 22, 2024, and ended on February 18, 2025. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Initially Not Met: 15

- §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.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.43 - Protective custody.
- §115.51 - Detainee reporting.
- §115.53 - Detainee access to outside confidential support services.
- §115.54 - Third-party reporting.
- §115.61 - Staff reporting duties.
- §115.78 - Disciplinary sanctions for detainees.
- §115.81 - Medical and mental health assessments; history of sexual abuse.

Number of Standards Exceeded: 0

Number of Standards Met: 15

- §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.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.43 - Protective custody.
- §115.51 - Detainee reporting.
- §115.53 - Detainee access to outside confidential support services.
- §115.54 - Third-party reporting.
- §115.61 - Staff reporting duties.
- §115.78 - Disciplinary sanctions for detainees.
- §115.81 - Medical and mental health assessments; history of sexual abuse.

Number of Standards Not Met: 0

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.

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

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

Notes:

(c): PISPC policy 4.5.13 states, "It is the policy of the Port Isabel Detention Center (PISPC) to ensure the safety and well-being of detainees housed at this facility. It is the responsibility of Immigration and Customs Enforcement (ICE) to protect detainees from sexual abuse, sexual harassment, personal injury and/or abuse. All sexual conduct between detainees, detainees and staff, volunteers, or contract personnel, regardless of consensual status, is strictly prohibited and subject to administrative, disciplinary, and criminal sanctions. Therefore, ICE has a standard of zero-tolerance for any form of said sexual activity. All PISPC staff, contract personnel, and volunteers are trained in the identification and reporting procedures of sexual assault or abuse." In review of the policy the Auditor confirmed the policy includes definitions of sexual abuse and general PREA definitions and 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 security inspections, mandatory reporting protocols, investigations, and support from victim advocates. During the on-site audit, the lead Auditor observed the DHS-prescribed sexual abuse and assault awareness notice posted in the housing units and programming areas of the facility. Interviews with eight random DOs confirmed they were knowledgeable regarding the facility and Agency zero-tolerance policy. The lead Auditor reviewed PISPC and confirmed the policy was approved by the AFOD.

(d): PISPC policy 4.5.13 states, "The Assistant Field Office Director (AFOD) will designate an ICE manager or designee as the SAAPI Program Coordinator. ICE Health Service Corps (IHSC) has also designated a staff member to assist the program coordinator. These program coordinators will be responsible for: assisting with the development of the written policies and procedures for the SAAPI Program and keeping them current; assisting with the development of initial and ongoing training protocols; making the SAAPI protocol available to the public by posting in the lobby entrance; serving as a liaison with other agencies; coordinating the gathering of statistics and reports on allegations of sexual abuse or assault, as detailed below in the section on Tracking Incidents of Sexual Abuse and Assault; reviewing the results of every investigation of sexual abuse and conduct an annual review of all investigations in compliance with the Privacy Act to assess and improve prevention and response efforts; and reviewing facility practices to ensure the required levels of confidentiality are maintained." The Auditor reviewed the facility Organizational Chart and confirmed the PSA Coordinator/PSA Compliance Manager is in a position of authority. Interviews with the AFOD and the PSA Coordinator/PSA Compliance Manager indicated the PSA Coordinator is assigned to another facility within the area and does not spend sufficient time at the facility; however, will visit the facility at least once during a two-week period. An interview with the PSA Coordinator /PSA Compliance Manager confirmed she serves as the point of contact for the Agency PSA Coordinator and has the authority necessary to oversee the facility's efforts to comply with the sexual abuse prevention and intervention policies and procedures; however, the Auditor could not confirm she has the time or an understanding of the PREA standards and their subsections, to efficiently assess, implement, and improve the facility's prevention and response to sexual abuse. During the on-site audit, any concerns the Auditor had, were discussed, and answered by the AIP Compliance Team; however, although, the team had

knowledge and could articulate the policies and procedures established to ensure compliance with some of the PREA standards, their lack of knowledge for all the PREA standards to ensure compliance was evident.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. The Auditor could not confirm the PSA Coordinator/PSA Compliance Manager had the time or an understanding of the PREA standards and all subsections, to efficiently assess, implement and improve the facility's prevention and response to sexual abuse. Interviews with the AFOD and the PSA Coordinator/PSA Compliance Manager indicated the PSA Coordinator is assigned to another facility within the area and does not spend sufficient time at the facility; however, will visit the facility at least once during a two-week period. During the on-site audit, any concerns the Auditor had, were discussed, and answered by the AIP Compliance Team; however, although, the team had knowledge and could articulate the policies and procedures established to ensure compliance with some of the PREA standards, their lack of knowledge for all the PREA standards to ensure compliance was evident. To become compliant, the facility shall ensure the designated PSA Compliance Manager has sufficient time within the facility to oversee the facility's efforts to comply with the sexual abuse prevention and intervention policies and procedures.

Corrective Action Taken:

The facility submitted a certificate confirming the PSA Coordinator has completed the ICE SAAPI training. In addition, the facility submitted an email confirming she has set aside one day each week to spend at the facility in order to effectively manage her responsibilities to oversee the facility's efforts to comply with the facility's sexual abuse prevention and intervention polices and procedures. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (d) of the standard.

<u>§115.13 - Detainee supervision and monitoring.</u>

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

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "PISPC will ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The AFOD will determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, PISPC will take into consideration generally accepted detention and correctional practices, any 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 as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors." PISPC currently employs 599 staff and contractor staff, which includes 26 AIP Management, 425 security staff (326 males and 99 females), 80 medical staff (14 IHSC, 6 Government Service, 60 contracted STG), and 5 contracted STG mental health. Additional staff include AGS food service. Maintenance services are provided by Chenega, Commissary staff by Keefe Commissary Network, and janitorial staff by Muvagi. Twenty-six volunteers employed by Jesuit Refugee Services provide religious services. Correctional staff work in three shifts 0700-1500, 1500-2300, 2300-0700. In addition, (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) . (b) (6), (b) (7)(C) During the on-site audit, the Auditor reviewed the facility comprehensive supervision guidelines and confirmed they are reviewed, and updated if needed, on an annual basis and each staff member is required to review the post order for their assigned post daily and confirm their review by signature in the post order

book. During the on-site audit, the Auditors observed there were no notable “blind spots” and there was adequate staffing throughout all areas of the facility. An interview with the FD indicated the facility has adequate staffing levels which are determined by the contract. An interview with the FD further indicated the staffing plan and the need for video monitoring are reviewed monthly; however, the FD could not articulate, how or if, the review takes into consideration the 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 as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors. During the on-site audit, with the assistance of the FD, the lead Auditor reviewed the contract; however, could not confirm the contract took into consideration all elements required by subsection (c) of the standard.

(d): PISPC policy 4.5.13 states, “Frequent unannounced security inspections will be conducted to identify and deter sexual abuse of detainees. Inspections will occur on night as well as day shifts. Staff is prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility.” An interview with the FD indicated all supervisors are required to conduct unannounced security inspections on each shift which are documented in red ink in the housing unit logbooks. An interview with a Shift Commander confirmed he conducts unannounced security inspections within the facility, was very knowledgeable, and could articulate unannounced security inspections are conducted to deter staff and detainees from participating in sexual abuse. An interview with a Shift Commander further confirmed if a staff member was found alerting other staff of the unannounced security inspections they could face disciplinary action. During the on-site audit, the Auditor reviewed the housing unit logbooks and confirmed unannounced security inspections were being conducted daily, on every shift, and at irregular times.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. An interview with the FD indicated the facility has adequate staffing levels which are determined by the contract. An interview with the FD further indicated the facility staffing plan is reviewed monthly; however, the FD could not articulate, how or if, the review takes into consideration the 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 as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors. During the on-site audit, with the assistance of the FD, the lead Auditor reviewed the contract; however, could not confirm the contract took into consideration all elements required by subsection (c) of the standard. To become compliant, the facility must submit documentation which confirms the facility took into consideration when determining adequate staffing levels and the need for video monitoring, generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody.

Corrective Action Taken:

The facility submitted an Annual PREA Facility Assessment that was completed on September 17, 2024. A review of the assessment confirms in determining adequate staffing levels and the need for video monitoring, the facility considered generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency

custody. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

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

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

Notes:

(b)(c)(d)(e)(f): PISPC policy 4.5.13 states, "Pat-down searches of male detainees by female staff will not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Pat-down searches of female detainees by male staff will not be conducted unless in exigent circumstances. All pat-down searches by staff of the opposite gender will be documented. Strip searches or visual body cavity searches by staff of the opposite gender will not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. All strip searches and visual body cavity searches will be documented." The lead Auditor reviewed two memorandums to the file which state, "Port Isabel Detention Center staff members did not conduct any cross-gender pat-down searches during the audit period" and "Port Isabel Detention Center staff members did not conduct any strip searches or visual body cavity searches during the audit period." Interviews with eight random DOs confirmed they were aware cross-gender pat-down searches, strip searches, cross-gender strip searches, or visual body cavity searches are strictly prohibited and are not to be conducted at the facility; however, if there are exigent circumstances requiring a cross gender search, it would be documented on a Record of Search form and an Incident Report would be completed. An interview with eight random DOs further indicated they have not witnessed or participated in a cross-gender pat-down search, a cross gender strip search, or a visual body cavity search during their employment with the facility. Interviews with 28 random detainees confirmed they had been subjected to a pat-down search conducted by a male officer; however, interviews with 2 additional detainees confirmed they could not remember if they had ever received a pat-down searched at the facility. Interviews with 30 random detainees confirmed they had not been strip searched at the facility. During the on-site audit, the lead Auditor observed a pat-down search of a detainee and confirmed the pat-down search was conducted by a male DO. The facility does not house juveniles.

(g): PISPC policy 4.5.13 states, "Detainees will be able 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 and hold room checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender will announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." Informal interviews with 5 random Compliance Team members indicated male officers are assigned posts in the male housing units to avoid cross-gender viewing allowing detainees to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender. During the on-site audit, the Auditors observed toilet and shower areas within all housing unit pods, as well as toilet areas throughout the facility and confirmed holding cells within visitation, had toilets which could be viewed from the windows, outside the holding cell; however, prior to the Auditors completing the on-site audit, the facility had installed a film over the windows to prevent viewing of the toilet from the windows. During the om-site audit the Auditors further observed in the shower areas of all housing unit pods, there was a half-wall which provided privacy for detainees while showering; however, the shower's dressing area was approximately three and half feet between the changing area and the shower area, leaving the detainee in a state of undress and visible from the large windows outside each pod which can be observed by female staff assigned to the housing unit control centers. In addition, during the on-site audit, (b) (7)(E) . The Auditors further observed signage outside each housing unit advising staff of the opposite gender to announce themselves prior to entering the housing units. Interviews with eight random DOs indicated female staff announce their presence if there is a need for

them to enter the housing units which was observed by the Auditors during the on-site audit. Interviews with 30 random detainees confirmed they are made aware of female staff prior to them entering the pod; however, female staff did not usually enter the housing units.
(h): PISPC is not designated as Family Residential Centers; and therefore, subsection (h) is not applicable.
(i)(j): PISPC policy 4.5.13 states, "PISPC will not search or physically examine a detainee for the sole purpose of determine the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. All pat-down searches will be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and procedures described in PISPC Policy 3.1.18 "Searches," including officer safety." The lead Auditor reviewed the ICE Cross-Gender, Transgender, and Intersex Searches training curriculum and confirmed the training curriculum includes, "All searches shall be performed in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety." Interviews with eight random DOs indicated each staff member is required to complete annual training in the proper procedures for conducting pat-down searches or cross-gender pat-down searches. Interviews with eight random DOs further confirmed they are notified if a transgender, or intersex, detainee will be arriving at the facility prior to the detainee's arrival at the facility; however, if a detainee's gender is unknown, they would consult with medical staff. In addition, interviews with eight random DOs further confirmed they have not witnessed or conducted a search of a detainee for the sole purpose of determining the detainee's gender while employed at the facility. An interview with a transgender detainee, indicated she did not believe she had been subjected to a search for the sole purpose to determine her genital status. An interview with a transgender detainee further indicated staff has been very professional and has allowed her to choose the gender of the officer who will conduct a pat-down search prior to performing the search. The Auditor reviewed 11 relevant staff files and confirmed each staff member had completed the ICE Cross-Gender, Transgender, and Intersex Search training.

Corrective Action:

The facility is not in compliance with subsection (g) of the standard. In the shower areas of all housing unit pods, the Auditor observed a half-wall which provided privacy for a detainee while showering; however, the shower area also has a dressing area on the opposite side of the shower with a built-in bench and hooks for the detainee to dress, undress, and hang their clothing to avoid the clothing getting wet from the shower water. However, there is approximately three and half feet between the changing area and the shower area, in which a detainee must walk to get to the shower, leaving the detainee's naked body exposed and visible from the large windows outside each pod in the secured area of the housing unit which is visible from the housing unit control center where female staff are assigned. To become compliant, the facility must submit documentation to confirm the facility implemented a practice to ensure detainees are able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender.

Corrective Action Taken:

The facility indicated that shower curtains have been installed in the shower/dressing area of the housing units. The facility submitted photographs to confirm the installation and that detainees in the state of undress could not be viewed from outside the pods by the housing unit control center or opposite gender staff walking past. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (g) of the standard.

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

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

Notes:

(a)(b): PISPC policy 4.5.13 states, "PISPC will take appropriate steps to 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 agency's efforts to prevent, detect, and respond to sexual abuse and assault. Such steps will include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, by: Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication. PISPC will take steps to ensure meaningful access to all aspects of the agency'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 interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary." Interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the facility's sexual abuse prevention and response. Interviews with 5 random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated all detainees are provided the ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the facility Detainee Handbook Local Supplement and will watch a PREA orientation video. In addition, interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated accommodations are made to ensure effective communication is established with detainees to include, but not limited to, the use of a teletypewriter (TTY) or Telecommunication device for the deaf (TDD) phone, video remote interpreting via I-pad, a hearing aid/amplifier, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated for detainees who have limited reading skills, or are limited English proficient (LEP), staff will utilize the facility language, or a staff interpreter, who is proficient in the detainee's preferred language line, to interpret the information. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated if a detainee is blind, the staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure the detainee understands the PREA material provided. During the on-site audit, the lead Auditor observed the ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet were readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese. In addition, the Auditor observed the facility Detainee Handbook Local Supplement, and confirmed it was readily available in 14 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. The lead Auditor reviewed the facility supplemental handbook and confirmed the handbook does not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. In an interview with 5 random Compliance Team members, it was indicated in addition to the facility supplemental handbook, the facility also provides detainees PREA information in a script available in English and Spanish and for those detainees whose preferred language is not English or Spanish, the script is read to the detainees with the use of the facility language line or a staff interpreter. Prior to the on-site audit, the Auditor reviewed the script and confirmed the script advised detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it did not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script, which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs

detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional information noted in the facility supplemental handbook. The lead Auditor reviewed 22 detainee files and confirmed 7 of the files included documentation to confirm detainees were provided with ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, the facility supplemental handbook, and the video; however, the video is not available in a manner all detainees can understand. A review of the detainee files further confirmed the documentation reviewed did not confirm the detainee acknowledged he had been provided the Detainee Education for Intake Staff Script. Interviews with 30 detainees confirmed they had received the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility supplemental handbook handbooks in their preferred language; however, did not confirm they had watched the PREA video or the received the Detainee Education for Intake Staff Script in a manner they could understand.
(c): PISPC policy 4.5.13 states, "In matters relating to allegations of sexual abuse, the facility will employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. PISPC will provide detainees with disabilities and detainees with limited English proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services will be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE/ERO determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse or assault, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse or assault." Interviews with eight random DOs indicated they could utilize another detainee for interpretation, if the detainee victim expressed a preference and the other detainee was not a witness, the abuser or someone with a significant relationship to the abuser. Interviews with eight random DOs further indicated they would seek the approval from their supervisor and the Agency prior to utilizing another detainee to interpret in matters related to sexual abuse and the approval and the circumstances surrounding the use of another detainee would be documented in an Incident Report and provided to the Investigator. The Auditor reviewed two sexual abuse allegation investigation files and confirmed there were no instances which included the use of a detainee for interpretation during the investigation.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. The lead Auditor reviewed the facility supplemental handbook and confirmed the handbook does not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script, which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional

information noted in the facility supplemental handbook. The lead Auditor reviewed 22 detainee files and confirmed 7 of the files included documentation to confirm detainees were provided with ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, the facility supplemental handbook, and the video; however, the video is not available in a manner all detainees can understand. A review of the detainee files further confirmed the documentation reviewed did not confirm the detainee acknowledged he had been provided the Detainee Education for Intake Staff Script. To become compliant, the facility must implement a practice to ensure all detainees have meaningful access to the facility's efforts to prevent, detect, and respond to sexual abuse, to include, but not limited to, information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. Once implemented the facility must submit documentation which confirms all Intake and Classification staff have received training on the implemented practice. The facility must submit 10 detainee files, to include if applicable, detainees who do not speak English or Spanish, who arrive during the corrective action plan (CAP) period to confirm detainees have meaningful access to the facility's efforts to prevent, detect, and respond to sexual abuse, to include, but not limited to, information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services.

Corrective Action Taken:

The facility submitted eight employee acknowledgements regarding the PISPC New Arrival Orientation Program form which states, "The employee acknowledges receipt, review and comprehensive understanding of the DHS/ICE-ERO New Arrival Orientation Program form with instructions, in relation to New Arrival Policies and Procedures set forth. Furthermore, the employee understands the importance of ensuring all detainees have meaningful access to the facility's efforts to prevent, detect and respond to sexual abuse. Orientation Video language and utilized method will be recorded on New Arrival Orientation Program Form." The facility submitted copies of the local detainee handbook in Chinese, Portuguese, and Turkish. The facility submitted a revised Detainee Education for Intake Staff Script. A review of the script confirms it includes information on the community-based organizations utilized by the facility to provide needed counseling and intervention services. In addition, the facility submitted the New Arrival Orientation Program document for five detainees, four whose preferred language was Spanish and one whose preferred language was English. The facility submitted five detainee files which included one Chinese detainee, three Portuguese detainees and one Turkish detainee. The Auditor reviewed the files and confirmed the facility provided each detainee the ICE National Detainee Handbook, the facility Detainee Handbook, the DHS Sexual Abuse and Assault Awareness Pamphlet, the Orientation Video Script, the facility Detainee Education for Intake Staff Script and Question and Answer Session, and translation services in the detainee's preferred language. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

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

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

Notes:

(a)(b)(c)(d)(e)(f): The 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)." PISPC policy 4.5.13 states, "PIDC will assure that an administrative or criminal investigation is

completed for all allegations of sexual abuse and sexual harassment. All reports are taken regardless of the source (detainee, staff or a third party) or the method of communication used (in writing, electronic, verbal, or any other source). The agency will ensure that the agency and facility protocols required by the paragraph above of this section, include a description of responsibilities of the agency, the facility, and any other investigating entities; and require the documentation and maintenance, for at least five (5) years, of all reports and referrals of allegations of sexual abuse. The agency will post its protocols on its Web site; the facility will also post its protocols on its Web site, if it has one, or otherwise make the protocol available to the public." PISPC policy 4.5.13 further states, "When a detainee(s) is alleged to be the perpetrator, it is the AFOD's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to the FOD, who will report it to the OPR Joint Intake Center. A Significant Event Notice (SEN) system report will also get generated. 2. When an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse and/or assault, the following will be notified immediately: the AFOD; the highest-ranking on-site ICE/ERO representative; the respective FOD; the FOD will notify: The Deputy Assistant Director, Detention Management Division, and The ICE Office of Professional Responsibility (OPR). OPR will refer the matter to the DHS Office of the Inspector General (OIG). The AFOD and/or FOD will also refer the matter to the FBI (or other appropriate law enforcement agency)." The lead Auditor reviewed PISPC policy 4.5.13 and confirmed although the policy does not include the verbiage 'require the documentation and maintenance, for at least five (5) years, of all reports and referrals of allegations of sexual abuse" it does require the documentation and maintenance of all reports and referrals of allegations of sexual abuse "in accordance with these standards;" and therefore, the lead Auditor accepts PISPC policy 4.5.13 for compliance. In an interview with the PSA Coordinator/PSA Compliance Manager it was indicated all allegations of sexual abuse are reported to the AFOD. In an interview with the AFOD it was indicated he would report the allegation to the FOD, Joint Intake Center (JIC), and ICE OPR. Interviews with the PSA Coordinator/PSA Compliance Manager and the facility PREA Investigator indicated that all allegations are immediately reported to the CCSO, and an administrative investigation would be coordinated with ICE OPR and CCSO to not interfere with a criminal investigation. The lead Auditor reviewed two investigative files and confirmed both allegations had been reported to the ICE FOD, CCSO, JIC, and the ICE OPR. The lead Auditor reviewed both the Agency website (https://www.ice.gov/prea) and the facility website (https://www.ice.gov/detain/detention-facilities/port-isabel-service-processing-center) and confirmed the Agency had posted their Administrative Investigation Protocols as required by the standard; however, PISPC policy 4.5.13 is not posted.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. The lead Auditor reviewed both the Agency website (https://www.ice.gov/prea) and the facility website (https://www.ice.gov/detain/detention-facilities/port-isabel-service-processing-center) and confirmed the Agency has posted their Administrative Investigation Protocols as required by the standard; however, PISPC policy 4.5.13 is not posted. During the on-site audit the Auditor further confirmed through observation the protocols are not available to the public. To become compliant the facility must make PISPC policy 4.5.13 available to the public.

Corrective Action Taken:

The facility submitted photographs to confirm the facility has posted PIDC Policy 4.5.13 in the facility lobby where visitors are processed; and therefore, the information included in PIDC Policy 4.5.13 is now available to the public. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

<u>§115.33 - Detainee education.</u>

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

Notes:

(a)(b)(c)(f): PISPC policy 4.5.13 states, "The AFOD will ensure that the orientation program required by the detention standard on Admission and Release, and the detainee handbook required by the detention standard on Detainee Handbook, notify and inform detainees about the PISPC's zero-tolerance policy for all forms of sexual abuse and assault. During the intake process, detainees are provided instruction on PISPC's SAAPI Program, instruction includes (at a minimum): PISPC's zero-tolerance policy for all forms of sexual abuse or assault; the name of the SAAPI Program Coordinator and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one (1) or more staff members other than an immediate point-of-contact line officer, the ICE/DRIL, the DHS/OIG and the ICE/OPR investigation processes or their consular official; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting an assault will not negatively impact the detainee's immigration proceedings; and right of a detainee who has been subjected to sexual abuse or assault to receive treatment and counseling. PISPC will provide the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. The above-mentioned detainee instruction will be documented, and such documentation will be maintained according to a prescribed schedule." Interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the facility's sexual abuse prevention and response. Interviews with 5 random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated all detainees are provided the ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the facility Detainee Handbook Local Supplement and will watch a PREA orientation video. In addition, interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated accommodations are made to ensure effective communication is established with detainees to include, but not limited to, the use of a teletypewriter (TTY) or Telecommunication device for the deaf (TDD) phone, video remote interpreting via I-pad, a hearing aid/amplifier, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated for detainees who have limited reading skills, or are limited English proficient (LEP), staff will utilize the facility language, or a staff interpreter, who is proficient in the detainee's preferred language line, to interpret the information. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated if a detainee is blind, the staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure the detainee understands the PREA material provided. During the on-site audit, the lead Auditor observed the ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet were readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese. The lead Auditor reviewed the ICE National Detainee Handbook and confirmed the handbook includes information about reporting sexual abuse. In addition, the Auditor observed the facility Detainee Handbook Local Supplement, and confirmed it was readily available in 14 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. The lead Auditor reviewed the facility supplemental handbook and confirmed the handbook does not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. In an interview with 5 random Compliance Team members, it was indicated in addition to the facility supplemental handbook, the facility also provides detainees PREA information in a script available in English and Spanish and for those detainees whose preferred language is not English or Spanish, the script is read to the detainees with the use of the facility language line or a staff interpreter. Prior to the on-site audit, the Auditor reviewed the script and confirmed the script advised detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to

avoid sexual abuse; however, it did not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional information noted in the facility supplemental handbook.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. The lead Auditor reviewed the facility supplemental handbook and confirmed the handbook does not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script, which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional information noted in the facility supplemental handbook. The Auditor reviewed the files of 10 newly arrived detainees who arrived at the facility following the implementation of the updated New Arrival Orientation Program form and confirmed the use of the New Arrival Orientation Program form. Interviews with 30 detainees confirmed they had received the ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the facility Detainee Handbook Local Supplement, and had seen the PREA Orientation Video: however, interviews could not confirm detainees had seen the video and received the Detainee Education for Intake Staff Script, in a manner they could understand. To become compliant, the facility must implement a practice to ensure during intake detainees receive an orientation program which includes information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. In addition, the facility must implement a practice that ensures detainees have access to the information provided in the PREA video in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all Intake and Classification staff have received training on the implemented practice. In addition, the facility must submit 10 detainee files, to include if applicable, detainees who do not speak English or Spanish, who arrived at the facility during the CAP period to confirm detainees receive an orientation program during intake which includes information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services and information provided in the PREA video in a manner all detainees can understand.

Corrective Action Taken:

The facility submitted eight employee acknowledgements regarding the PISPC New Arrival Orientation Program form which states, “The employee acknowledges receipt, review and comprehensive understanding of the DHS/ICE-ERO New Arrival Orientation Program form with instructions, in relation to New Arrival Policies and

Procedures set forth. Furthermore, the employee understands the importance of ensuring all detainees have meaningful access to the facility's efforts to prevent, detect and respond to sexual abuse. Orientation Video language and utilized method will be recorded on New Arrival Orientation Program Form." The facility submitted copies of the local detainee handbook in Chinese, Portuguese, and Turkish. The facility submitted a revised Detainee Education for Intake Staff Script. A review of the script confirms it includes information on the community-based organizations utilized by the facility to provide needed counseling and intervention services. In addition, the facility submitted the New Arrival Orientation Program document for five detainees, four whose preferred language was Spanish and one whose preferred language was English. The facility submitted five detainee files which included one Chinese detainee, three Portuguese detainees and one Turkish detainee. The Auditor reviewed the files and confirmed the facility provided each detainee the ICE National Detainee Handbook, the facility Detainee Handbook, the DHS Sexual Abuse and Assault Awareness Pamphlet, the Orientation Video Script, the facility Detainee Education for Intake Staff Script and Question and Answer Session, and translation services in the detainee's preferred language. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d)(f)(g): PISPC policy 4.5.13 states, "Detainees will be screened upon arrival at the facility for potential vulnerabilities to sexually aggressive behavior or tendencies to act out with sexually aggressive behavior and will be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new arrival will be kept separate from the general population until he or she is classified and may be housed accordingly. The initial classification process and initial housing assignment will be completed within twelve (12) hours of admission to the facility. The facility will consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: 1. whether the detainee has a mental, physical, or developmental disability; 2. the age of the detainee; 3. the physical build and appearance of the detainee; 4. whether the detainee has previously been incarcerated or detained; 5. the nature of the detainee's criminal history; 6. whether the detainee has any convictions for sex offenses against an adult or child; 7. whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; 8. whether the detainee has self-identified as having previously experienced sexual victimization; and 9. the detainee's own concerns about his or her physical safety. Detainees will not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to items (1), (7), (8), or (9) above. The initial screening will consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to PISPC, in assessing detainees for risk of being sexually abusive. The facility will implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees." PISPC policy 4.5.13 further states, "Detainees will be screened within twenty-four (24) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior. The Processing Officer will make a housing determination during the admission review (classification) of past and current criminal history. A detainee(s) considered to be a possible sexual predator will be segregated from the general population and housed in the Special Management Unit (SMU). The medical department will assess all detainees identified as a high risk with a history of any type of sexual behavior or at risk for victimization." The lead Auditor reviewed the facility Detainee Classification Risk Assessment and confirmed the assessment considers whether the detainee has a mental, physical, or developmental disability; the age of the detainee, the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; the detainee's own concerns about his or her physical safety;

prior acts of sexual abuse; prior convictions for violent offenses; and a history of prior institutional violence or sexual abuse. A review of the facility Detainee Classification Risk Assessment further confirms the assessment requires staff complete the form within 12 hours; however, PISPC policy 4.5.13 requires staff screen the detainee within twenty-four (24) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior. In addition, a review of the facility Detainee Classification Risk Assessment confirms the assessment includes boxes which indicate time in and time out of the "staging" area. Interviews with an Intake Officer and a Classification Officer indicated detainees arrive through the sally port, are placed into holding cells, within a "staging" area which is used to hold both detainees being processed for admittance into PISPC, and detainees being transported to other facilities, where they are assessed to identify those likely to be sexual aggressors or sexual abuse victims. Interviews with an Intake Officer and a Classification Officer further indicated once the detainee is accepted for housing at the facility the detainee is moved to the PISPC intake area, for completion of the classification process which includes a medical assessment and initial housing assignment. An interview with a Classification Officer indicated the "staging" area where detainees are assessed, is not considered to be part of PISPC; and therefore, staff will complete the "time in" and "time out" boxes on the assessment to confirm the time the detainee arrived and entered the "staging" area from the sally port and the time the detainee is accepted into PISPC. However, during the on-site audit, the lead Auditor, confirmed with the ERAU team lead, the "staging area" at PISPC does not include a designation as a staging facility. Therefore, the time a detainee is housed in the "staging" area must be included, when calculating the 12-hour limit to complete initial classification and housing as required by subsection (b) of the standard. Interviews with an Intake Officer and a Classification Officer indicated detainees pending acceptance into PISPC are kept separate from detainees who are being transferred or housed in general population. During the on-site tour the lead Auditor observed the intake staging area and confirmed the area has five to six stations to allow multiple detainees to be processed at one time. During the on-site audit, the Auditor further observed detainees are brought out in multiple numbers to be assessed with no privacy barrier between detainees to allow for confidentiality and to ensure sensitive information obtained from the assessment is not overheard by other staff, other detainees or inmates, which is exaggerated when intake staff must utilize a speaker phone to access the language line services for interpretation. Interviews with the Disciplinary Officer, Classification Officer, and an Intake Officer, indicated detainees are not disciplined if they refuse to answer or provide complete answers on risk assessment. The lead Auditor reviewed seven detainee files and confirmed the facility Detainee Classification Risk Assessment indicated the detainee's date and time of arrival at PISPC; however, during the on-site audit the facility submitted a Male Incoming roster and housing unit logs which confirmed the facility is not taking into consideration the time spent in the "staging" area as part of the required twelve hours from admission to complete the detainees initial classification and housing. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer confirmed they could not provide the Auditor, the names of the detainees who experienced sexual abuse or where sexual abuse perpetrators, or where they are housed in the facility. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer further confirmed staff could not articulate the housing process to prevent sexual abuse or the steps the facility takes to mitigate any such dangers. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be a sexual aggressors or sexual abuse victims until medical provided a listing of detainees based on the initial medical assessment. However, due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews or review intake, medical, and mental health records; and therefore, could not confirm the facility takes into consideration the elements required by subsection (c) of the standard to determine initial housing. During the on-site audit the lead Auditor observed and confirmed detainee files containing the initial risk assessment are filed in a secure area under lock and key.

(e): PISPC policy 4.5.13 states, "PISPC will reassess each detainee's risk of victimization or abusiveness between sixty (60) and ninety (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." PISPC policy 4.5.13 further states, "Classification is an ongoing, dynamic process. A detainee

who is subjected to sexual abuse or assault will not be returned to general population until proper re-classification, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault, is completed." An interview with a Classification Officer indicated the facility reassesses each detainee's risk of victimization or abusiveness at sixty days from the date of the detainee's arrival at the facility. The interview further indicated a reassessment would be conducted based on new information learned or following an incident of sexual abuse or victimization. The Auditor reviewed seven detainee files; however, none of the detainee files indicated the detainee had been at the facility for 60 days; and therefore, the Auditor requested and reviewed 10 detainee risk reassessments and confirmed the reassessment had been completed at 60 days from the date of the initial assessment. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither detainee victim had been reassessed following the incident of abuse or victimization.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (g) of the standard. A review of the Detainee Classification Risk Assessment confirms it requires staff complete the initial risk assessment within 12 hours; however, PISPC policy 4.5.13 states, "Detainees will be screened within twenty-four (24) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior." In addition, a review of the facility Detainee Classification Risk Assessment confirms the assessment includes boxes which indicate time in and time out of the "staging" area and not the designated intake area. Interviews with an Intake Officer and a Classification Officer indicated once the detainee is accepted for housing at the facility the detainee is moved to the PISPC intake area, for completion of the classification process which includes a medical assessment and initial housing assignment. An interview with a Classification Officer indicated the "staging" area is where detainees are screened, and it's not considered to be part of PISPC. However, during the on-site audit, the lead Auditor, confirmed with the ERAU team lead, the "staging area" at PISPC does not include a designation as a staging facility. Therefore, the time a detainee is housed in the "staging" area must be included, when calculating the 12-hour limit to complete initial classification and housing as required by subsection (b) of the standard. During the on-site audit, the Auditor observed the intake area and confirmed there is no privacy barrier between detainees to allow for confidentiality and to ensure sensitive information gained from the initial assessment, is not overheard by other staff or detainees. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer confirmed they could not provide the Auditor, the names of detainees who identify as victims or sexual abuse or sexual perpetrators, or where they are housed in the facility. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer further confirmed staff could not articulate the housing process to prevent sexual abuse or the steps the facility to takes to mitigate any such dangers. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or sexual abuse victims until medical provided a listing of detainees based on the initial medical assessment. However, due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews or review intake, medical, and mental health records; and therefore, could not confirm the facility takes into consideration the elements required by subsection (c) of the standard to determine when determining initial housing. The lead Auditor reviewed seven detainee files and confirmed the facility Detainee Classification Risk Assessment facility jail management documentation indicated the detainee's date and time of arrival at PISPC; however, during the on-site audit the facility submitted a Male Incoming roster and housing unit logs which further confirmed the time indicated on the risk assessment as the "time out" of the staging area; and therefore, the facility is not taking into consideration the time spent in the "staging" area as part of the required twelve hours from admission to complete the detainees initial classification and housing. To become compliant, the facility must implement a practice which includes assessing detainees within twelve (12) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate such danger. In addition, the facility must develop and implement appropriate controls to ensure information gained during the initial risk assessment is not exploded to the detainee's detriment by staff, other detainees, or inmates. Once implemented the facility must submit documentation which

confirms all applicable staff, to include Intake, Classification, and security supervisors, have been trained on the implemented practice. In addition, the facility must submit 10 detainee files who arrive during the CAP period to confirm the required practices have been implemented.

The facility is not in compliance with subsection (e) of the standard. An interview with a Classification Officer indicated a risk reassessment would be conducted following an incident of sexual abuse or victimization. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither detainee victim had been reassessed following the incident of abuse or victimization. To become compliant, the facility must submit documentation to confirm all applicable staff, to include facility investigators, have received training on the standard's requirement to reassess a detainee's risk for sexual victimization following an incident of sexual abuse or victimization. In addition, if applicable, the facility must submit all sexual abuse investigation files which occur during the corrective action plan (CAP) period to confirm a reassessment had been completed after an incident of sexual abuse or victimization.

Corrective Action Taken:

The facility submitted eight employee training acknowledgements which state, "The employee acknowledges receipt, review and comprehensive understanding of the DHD/ICE-ERO Detainee Classification Risk Assessment form with instructions, in relation to the Classification Post Policies and Procedures set forth. Furthermore, the employee understands the importance of assessing detainees within twelve (12) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior and shall house the detainees to prevent sexual abuse, taking necessary steps to mitigate such dangers. Information gained during the initial risk assessment is not exploited to the detainee's detriment by staff, other detainees, or inmates." The facility submitted 10 detainee Classification Risk Assessments, the corresponding booking card and the corresponding housing cards for detainees who had arrived at the facility during the CAP period. The Auditor reviewed the submitted documentation and confirmed all detainees were assigned to the housing unit determined to be an appropriate assignment based on the information gained from the initial risk assessment. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b) and (g) of the standard.

§115.42 - Use of assessment information.

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

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "The facility will use the information from the risk assessment to inform assignment of detainees to housing, recreation and other activities, and voluntary work. The agency will make individualized determinations about how to ensure the safety of each detainee." PISPC policy 4.5.13 further states, "When making assessment and housing decisions for a transgender or intersex detainee, the facility will consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility will consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs will always be taken into consideration as well. The facility's placement of a transgender or intersex detainee will be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee will be reassessed at least twice each year to review any threats to safety experienced by the detainee. When operationally feasible, transgender and intersex detainees will be given the opportunity to shower separately from other detainees." In addition, PISPC policy 4.5.13 states, "Detainees will be screened within twenty-four hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior. The Processing Officer will make housing determinations during the admission review (classification) of past and current criminal history. A detainee(s) considered to be a possible sexual predator will be segregated from the general

population and housed in the Special Management Unit (SMU)." Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team confirmed they could not provide the Auditor with the names of the detainees who identified as to be sexual abuse aggressors or sexual abuse victims during intake or where they are housed in the facility. Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team further confirmed they could not articulate how the facility utilizes the information obtained from the risk assessment, in making individualized determination that can ensure the detainee's safety, for the assignment of housing, recreation, voluntary work or other activities. Interviews with a Classification Officer and an Intake Officer indicated medical and mental health are consulted on the placement of all detainees including transgender or intersex detainees. In an interview with a Classification Officer it was indicated, a transgender or intersex detainee will be reassessed twice a year to ensure his/her safety. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or sexual abuse victims. During the exit briefing, medical staff provided the Auditor a medical roster of those detainees that had been identified as an aggressor or as a sexual abuse victim, based on the initial medical assessment conducted; however, due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews or review detainee, medical, and mental health files to determine if the initial risk assessment is considered in determining housing, recreation, programming and other activities. An interview with the AHSA indicated housing for a transgender or intersex detainee is determined based on the detainee's own self-identification of gender and not by physical anatomy; however, the safety and security of the facility is also considered. An interview with the AHSA further indicated a transgender/intersex detainee is initially housed in the medical unit until the Transgender Care Committee (TCC) can meet and discuss the detainee's placement, which will occur within 72 hours. An interview with a transgender detainee indicated she is housed in the medical unit and has been housed in the medical unit since arriving at the facility approximately 10 days earlier; however, an interview with the AHSA confirmed the transgender detainee remained in the medical unit due her classification level and not due to being vulnerable to sexual abuse. The lead Auditor reviewed the transgender's file and confirmed the transgender detainee was seen by the TCC within 72 hours and her placement in medical was due to a classification issue and not due to her being vulnerable to sexual abuse. An interview with eight random DOs and a transgender detainee indicated all transgender/intersex detainees are given the an opportunity to shower separately from other detainees in the medical area.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be a sexual aggressor or sexual abuse victims. Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team confirmed they could not provide the Auditor with the names of the detainees who identified as to be sexual abuse aggressors or sexual abuse victims during intake or where they are housed in the facility. Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team further confirmed they could not articulate how the facility utilizes the information obtained from the risk assessment, in making individualized determination that can ensure the detainee's safety, for the assignment of housing, recreation, voluntary work or other activities. Interviews with a Classification Officer and an Intake Officer indicated medical and mental health are consulted on the placement of all detainees including transgender or intersex detainees. During the exit briefing, medical staff provided the Auditor a medical roster of those detainees that had been identified as an aggressor or as a sexual abuse victim, based on the initial medical assessment conducted, during the intake process; however due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews to determine if a process has been established to mitigate any dangers. To become compliant, the facility shall develop and implement a process to utilize the information from the risk assessment to inform assignment of detainees to housing, recreation, and voluntary work or other activities. Once implemented, the facility shall submit documentation to confirm all applicable staff, to include intake, medical and classification staff, have been trained on the implemented process. In addition, the facility shall provide the Auditor 10

detainee files to confirm information obtained from the risk assessment was utilized to determine the detainees housing, recreation, and voluntary work or other activities.

Corrective Action Taken:

The facility submitted five employee acknowledgments which states, “The employee acknowledges receipt, review and comprehensive understanding of the DHD/ICE-ERO Detainee Classification Risk Assessment form with instructions, in relation to the Classification Post Policies and Procedures set forth. Furthermore, the employee understands the importance to utilize the information from the risk assessment to inform assignment of detainees to housing, recreation, voluntary work, or other activities.” The facility submitted a tracking system spreadsheet which included 11 detainees received at the facility during the CAP period. The Auditor reviewed the spreadsheet and confirmed the spreadsheet includes information on housing, recreation and other activities, and voluntary work which had been assigned to each detainee on the list. The facility submitted documentation to confirm 10 staff members (3 medical, 5 security, and 2 food service) received training on the importance of utilizing the information gained from the initial risk assessment to inform assignment of detainees to housing, recreation and other activities, and voluntary work. The facility submitted 10 detainee files to confirm information obtained from the risk assessment was utilized to determine recreation and other activities and voluntary work; however, the facility did not submit the corresponding housing card; and therefore, the Auditor could not confirm the facility is utilizing the information gained from the initial risk assessment to inform assignment of detainees to housing. The facility submitted the corresponding housing cards for the 10 detainee risk assessments provided for review on 11/20/24. The Auditor reviewed the submitted cards in conjunction with the initial risk assessments previously provided and confirmed all detainees were assigned to the housing unit determined to be an appropriate assignment based on the information gained from the initial risk assessment. The facility submitted 10 staff training memorandums which states, “The employee acknowledges receipt, review, and comprehensive understand of the DHS/ICE ERO Detainee Classification Risk Assessment Form with instructions in relation to the Classification Post Policies and Procedures set forth. Furthermore, the employee understands on how detainees are placed on the implemented PIDC Housing Tracking System Spreadsheet and how staff will utilize the implemented spreadsheet to inform housing, recreation and other activities, and voluntary work.” Upon review of all available documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c)(d)(e): PISPC policy 4.5.13 states, “The facility will develop and follow written procedures consistent with the standards in Protective Custody for the facility governing the management of its administrative segregation unit. The procedures will be developed in consultation with the ICE Enforcement and Removal Operations Field Office Director having jurisdiction for the facility and must document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at PISPC, the facility will consult with the FOD for additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, regular review of detainee must be provided. The Contract Security Shift Commander will conduct a review within seventy-two (72) hours of a detainee’s initial placement in administrative segregation to determine if administrative segregation is warranted. The status of all detainees will be reviewed by a Contract Security Shift Commander after the detainee has spent seven (7) days in administrative segregation, and every week thereafter, for the first thirty (30) days and every ten (10) days thereafter, at a minimum. Such an assignment will not ordinarily exceed a period of thirty (30) days.” PISPC policy 4.5.13 further states, “Care will be taken to place the detainee in a supportive environment that represents the least restrictive housing option possible (e.g.

protective custody), and to the extent possible, permit the victim the same level of privileges he or she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical and mental health needs of the alleged victim. However, victims will not be held for longer than five (5) days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. PISPC will notify the FOD no later than seventy-two (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 lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy does not include the requirement to document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. The Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center has no record of a detainee in protective custody/administrative segregation that demonstrates a review by supervisor staff at the following intervals: within 72 hours of placement, every 7 days for the first month and, if necessary, every 10 days thereafter that has occurred during the audit period at the Port Isabel Detention Center." An interview with the FD and Auditor observations, confirmed the facility does not have an administrative segregation/protective custody unit and if a detainee is at risk for sexual victimization, the detainee would be moved to another unit, where he would be able to participate in programs, visitation, counsel, and all other services available to the general population. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy was developed in consultation with the AFOD.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy does not include the requirement to document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. To become compliant the facility must submit documentation to confirm PISPC policy 4.5.13 was updated in consultation with the FOD to include the requirement to document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Once updated the facility must submit documentation to confirm all security staff were trained on updated PISPC policy 4.5.13.

Corrective Action Taken:

The facility submitted a revised policy 4.5.13. The revisions included combining all information regarding the procedures for administrative segregation to only one section of the policy which states, "Supervisors placing a detainee in SMU under administrative segregation based on a vulnerability to sexual abuse, sexual assault, or a possible sexual predator will complete the Administrative Segregation Form identifying the detainee as a "Security Risk". The Supervisor will submit a supporting memorandum identifying the detailed reasons for the detainee's placement in SMU. A copy of this memorandum will be placed in the segregation file and detention file. The Assistant Field Office Director (AFOD) will be immediately notified of any placements in SMU under these circumstances. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at PIDC, the facility will consult with the FOD for additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, regular review of detainee must be provided." The facility submitted a memorandum which confirms revised policy 4.5.13 has been reviewed and approved by the Field Office Director. In addition, the facility submitted 10 employee acknowledgments which state, "The employee acknowledges receipt, review and comprehensive understanding of the DHD/ICE-ERO Protective Custody and Process with instructions, in relation to Sexual Abuse and Assault Prevention and Intervention Policies and Procedures set forth. Furthermore, the employee understands the importance of ensuring to document detailed reasons for placement of an individual in administrative segregation, on the basis of vulnerability to sexual abuse or assault." Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.51 - Detainee reporting.

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

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "The PISPC Detainee Handbook provides instructions for detainees to immediately report an incident of sexual assault/abuse. Any report, whether verbal, in written, anonymously and from third parties may be submitted to any staff member. Reports of sexual abuse/assault or attempted sexual abuse/assault allegations will be immediately forwarded to an ICE Supervisor on duty or designee. Detainees will have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse or assault, and/or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting." The Detainee Handbook Local Supplement states, "Detainees have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting." Interviews with 5 random Compliance Team members and eight random DOs indicated detainees are provided multiple ways to report an allegation of sexual abuse, retaliation, and/or any staff neglect of their responsibilities which may have contributed to an incident of sexual abuse. During the on-site audit, the lead Auditor observed PREA information in all common areas of the facility and near the detainee telephones in English and Spanish which included the DHS-prescribed sexual assault notice, the Detention and Reporting Information Line (DRIL) poster, DHS Office of Inspector General (OIG) poster, the Rape Abuse, and Incest National Network (RAINN) poster, the facility PREA Hotline number, Sexual Assault Victim Service Provider flyer, and information for contacting consular officials. However, during the on-site audit, the lead Auditor reviewed the written information provided to all detainees during intake/orientation and confirmed written information provided did not include the information available in the Sexual Assault Victim Service Provider flyer in a manner all detainees can understand. In addition, during the on-site audit, the lead Auditor tested the telephone numbers provided for the DRIL and DHS OIG and confirmed they were in good working order; however, the Auditor utilizing a detainee pin number, tested the number posted for the PISPC PREA Hotline by leaving a message with instructions to immediately inform the PSA Compliance Manager or the Audit Team once it had been received; however, neither PSA Compliance Manager or the Audit Team received a response; and therefore, the Auditors could not confirm the PISPC PREA Hotline provided by the facility to report an allegation of sexual abuse is in good working order. Interviews with 30 random detainees indicated they were aware there were several ways they could report an allegation of sexual abuse at PISPC, including ways to report anonymously, if needed.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. PISPC policy 4.5.13 states, "The PISPC Detainee Handbook provides instructions for detainees to immediately report an incident of sexual assault/abuse. Any report, whether verbal, in written, anonymously and from third parties may be submitted to any staff member. Reports of sexual abuse/assault or attempted sexual abuse/assault allegations will be immediately forwarded to an ICE Supervisor on duty or designee." However, during the on-site audit the lead Auditor tested the facility PREA hotline number by leaving a message with instructions to immediately inform the PSA Compliance Manager or the Audit Team once the message was received and did not get a response. To become compliant, the facility must submit documentation to confirm the facility PREA Hotline, provided to the detainees, is in good working order.

Corrective Action Taken:

The facility submitted email documentation which confirmed a detainee had made a call to the facility PREA Hotline and received a response confirming the PREA Hotline is in good working order. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d): PISPC policy 4.5.13 states, "Detainee will be informed prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. If available and offered by a community facility, prophylactic treatment, emergency contraception and follow-up examinations for sexually transmitted diseases will be offered to all victims, as appropriate." PISPC policy 4.5.13 further states, "Reports to Outside Agencies that have a Memoranda of Understanding with the Facility

- Friendship of Women, Inc. 95 East Price Rd. Brownville, Texas 78521, Hotline (956) 544-7412
- Family Crisis Center, Inc., 616 West Taylor Ave., Harlingen, TX 78550, Hotline (956) 423-9304
- Women Together/Mujeres Unidas, 511 North Cynthia St., McAllen, TX 78501, Hotline (800) 580-4879"

During the on-site audit the lead Auditor reviewed the Detainee Handbook Local Supplement and confirmed the handbook states, Outside agencies may forward any reports of abuse to the facility and authorities in accordance with mandatory reporting laws. Such communications will be monitored." A review of the Detainee Handbook Local Supplement further confirmed the handbook includes, "Emotional support is available from the facility's mental health and medical staff, and from the chaplains." Interviews with 5 random Compliance Team members indicated the facility maintains a Memorandum of Understanding (MOU) with Women Together/Mujeres Unidas. The Auditor reviewed the MOU, dated March 18, 2024, with no expiration date, between Women Together/Mujeres Unidas and PISPC and confirmed the MOU states, "Women Together/Mujeres Unidas agrees that ERO Harlingen at PIDC may post their contact information throughout the facility as part of the PIDC "Safe Hotline, Sexual Assault Victim Service Providers" flyer. Contact phone numbers and email addresses are displayed on the flyer." A review of the MOU further confirms Women Together/Mujeres Unidas will provide counseling, at no cost to the detainee, if requested by the detainee;" however, the MOU does not include the standard's requirements to provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, and legal advocacy as required by subsection (a) of the standard. During the on-site audit, the Auditor observed the Sexual Assault Victim Service Provider flyer located within the Wall Reference Organizer posted in each housing unit. The Auditor reviewed the flyer and confirmed the flyer was in English and Spanish, provided phone numbers for Friendship of Women, the Family Crisis Center, Inc., and Women Together/Mujeres Unidas, and did not provide the detainee with mailing addresses; however, upon notification the facility updated and reposted the flyers. During the on-site audit the Auditor further observed a flyer with instructions on how to place an anonymous calling, in English and Spanish, posted in the housing units and confirmed the poster include how to place an anonymous call to the DRIL, DHS OIG, Joint Intake Center (JIC), National Rape Hotline, the State Sexual Abuse Hotline, and an Emergency Hotline. However, during the on-site audit, the lead Auditor reviewed the written information provided to all detainees during intake/orientation and confirmed written information provided did not include the information available in the Sexual Assault Victim Service Provider flyer in a manner all detainees can understand. The Auditor tested all numbers provided and confirmed the State Sexual Abuse Hotline and a number assigned to "Outside PREA", indicated these numbers did not exist. A test of the posted numbers further confirmed there was no anonymous number posted for the local Sexual Assault Service Provider. Upon notification the Compliance Team immediately worked with Talton to repair the issues and once the issues had been repaired, the Compliance Team replaced all the instruction flyers within the units, Talton sent out a broadcast to all detainee tablets to inform the detainee of the changes, and the lead Auditor tested all numbers, utilizing the detainee phones, and confirmed they were in good working order. During the on-site audit the lead Auditor contacted, via telephone, Women Together/Mujeres Unidas and spoke with a victim advocate. In an interview with the advocate, it was confirmed the advocate was not aware of the MOU and would not provide services to detainees at PISPC; however, if a detainee were to call the hotline, or needed a SANE examination, they would transfer them to another agency closer to the facility to provide the needed services. The lead Auditor unsuccessfully attempted to call the Executive Director of Women Together/Mujeres Unidas; and

therefore, could not confirm the organization would provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, or legal advocacy as required by subsection (a) of the standard. Interviews with 30 random detainees confirmed they were not aware of the services provided for emotional support to most appropriately address their needs should they be a victim of sexual abuse. The facility did not provide MOUs for either Friendship of Women or the Family Crisis Center, Inc, as noted in PISPC policy 4.5.13.

Corrective Action:

The facility is not in compliance with subsections (a) and (c) of the standard. The Auditor reviewed an MOU, dated March 18, 2024, with no expiration date, between Women Together/Mujeres Unidas and PISPC and confirmed the MOU states, "Women Together/Mujeres Unidas if requested the organization will provide counseling services at no cost to the detainee; however, the MOU does not include the standard's requirements to provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, and legal advocacy as required by subsection (a) of the standard." During the on-site audit the lead Auditor contacted, via telephone, Women Together/Mujeres Unidas and spoke with a victim advocate. In an interview with the advocate, it was confirmed the advocate was not aware of the MOU and would not provide services to detainees at PISPC; however, if a detainee were to call the hotline, or needed a SANE examination, they would transfer them to another agency closer to the facility to provide the needed services. The lead Auditor unsuccessfully attempted to call the Executive Director of Women Together/Mujeres Unidas; and therefore, could not confirm the organization would provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, or legal advocacy as required by subsection (a) of the standard. During the on-site audit, the lead Auditor reviewed the written information provided to all detainees during intake/orientation and confirmed written information provided did not include the information available in the Sexual Assault Victim Service Provider flyer in a manner all detainees can understand. To become compliant, the facility must maintain or attempt to enter into a MOU with an outside organization to provide detainee victims of sexual abuse with crisis intervention, investigation and prosecution of sexual abuse perpetrators, and legal advocacy as required by subsection (a) of the standard. In addition, the facility must implement a practice to ensure detainees are provided the information available in the Sexual Assault Victim Service Provider flyer prior to in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all Intake and Classification staff have received training on the standard's requirement to make available to detainees information about local organizations that can assist detainees who have been victims of sexual abuse in a manner all detainees can understand.

Corrective Action Taken:

The facility submitted an MOU between ICE, PIDC, and the Women Together/Mujeres Unidas. The revised MOU states (a) Women Together/Mujeres Unidas agrees that ERO Harlingen at PIDC may post their contact information through out the facility as part of the PIDC "Safe Hotline, Sexual Assault Victim Service Providers" flyer. Contact phone numbers, mailing, and email address are displayed on the flyer. (b) Women Together/Mujeres Unidas will provide counseling, at no cost to the detainee, if requested by the detainee. (c) If it is perceived by Women Together/Mujeres Unidas through providing counseling to the detainee that a criminal act has occurred, Women Together/Mujeres Unidas will notify either ERO Harlingen or the appropriate law enforcement agency for the area for which the criminal act occurred. (d) Provide valuable expertise and support in the areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse perpetrators to most appropriately address victims' needs." The facility submitted eight employee acknowledgements that states, "The employee acknowledges receipt, review and comprehensive understanding of the DHS/ICE-ERO Sexual Abuse Victim Service Provider Flyer with instructions, in relation to Outside Confidential Support Services Policies and Procedures set forth. Furthermore, the employee understands the importance of ensuring all detainees' information about local organizations that can assist detainees who have been victims of sexual abuse are available in a manner all detainees can understand." The facility submitted a revised Detainee Education for Intake Staff Script. A review of the script confirms it includes information on the community-based organizations utilized by the facility to provide needed counseling and intervention services. The facility submitted the New

Arrival Orientation Program document for five detainees. The document confirms five detainees reviewed the Orientation Video or had the information translated in a language they could understand, were given an opportunity to participate in questions and answers, in a language they could understand. In addition, the facility submitted 10 employee acknowledgments which state, "The employee acknowledges receipt, review and comprehensive understanding of the DHS/ICE-ERO New Arrival Orientation Program Form with instructions, in relation to New Arrival Policies and Procedures set forth. Furthermore, the employee understands the importance of ensuring all detainees have meaningful access to the facility's efforts to prevent, detect and respond to sexual abuse. Orientation Video language and utilized method will be recorded on New Arrival Orientation Program Form." Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (c) of the standard.

§115.54 - Third-party reporting.

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

Notes:

PISPC policy 4.5.13 states, "PISPC will establish a method to receive third-party reports of sexual abuse in its facility and will make available to the public information on how to report sexual abuse on behalf of a detainee. PISPC provides detainees and their attorneys, family, friends, and associates multiple ways to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. Third parties not connected to a detainee can also report these allegations. Reports are confidential and may be made anonymously, both verbally and in writing." A review of the facility website (https://www.ice.gov/detain/detention-facilities/port-isabel-service-processing-center) confirmed the facility provides the public with multiple ways to report sexual abuse, retaliation for reporting sexual abuse, staff neglect, or violations of responsibilities that may have contributed to such incidents, on behalf of a detainee. A review of the facility website further confirms the website provides addresses and telephone number for the DHS OIG, the DRIL, and ICE OPR. A review of the Agency website (www.ice.gov/prea) confirmed it provides the public with information (telephone number & address) regarding third-party reporting of sexual abuse on behalf of the detainee to include the DHS OIG, the DRIL, and ICE OPR. The lead Auditor tested the phone number for the DHS OIG and confirmed it is in good working order. In addition. the lead Auditor tested the telephone number for the DRIL and confirmed it was in good working order; however, the lead Auditor completed the on-line reporting form, and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the form is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the form provided by the Agency to report an allegation of sexual abuse was in good working order. The Auditor tested the telephone number for ICE OPR and confirmed it was in good working order; however, the Auditor sent an email to the address provided and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the email address is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the email address provided by the Agency to report an allegation of sexual abuse was in good working order.

Corrective Action:

The Agency is not compliant with standard 115.54. The lead Auditor tested the telephone number for the DRIL and confirmed it was in good working order; however, the lead Auditor completed the on-line reporting form, and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the form is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the form provided by the Agency to report an allegation of sexual abuse was in good working order. The Auditor tested the telephone number for ICE OPR and confirmed it was in good working order; however, the Auditor sent an email to the address provided and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the email address is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the email address provided by the Agency to report an allegation of

sexual abuse was in good working order. To become compliant the Agency must submit documentation which confirms all resources provided by the Agency to report an allegation of sexual abuse are in good working order.

Corrective Action Taken:

The Agency submitted a test email to the DRIL which confirms the test email was sent on November 12th, 2024. A review of the test email further confirms the test email was received on November 12th, 2024, and is being processed confirming the DRIL is in good working order. Upon review of all submitted documentation the Auditor now finds the facility in compliance with the standard.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." 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." PISPC policy 4.5.13 states, "Staff must report any knowledge, suspicion, or information regarding an incident of 1) sexual abuse that occurred in the facility; 2) retaliation against detainees or staff that reports, complains about, or participated in an investigation about sexual abuse or assault; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff must also be able to report the above outside of the chain of command and accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." Interviews with eight random DOs confirmed they were very knowledgeable and could articulate their responsibilities to immediately 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. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy does not include an avenue in which staff can make a report of sexual abuse outside the chain of command. Interviews with eight random DOs further confirmed they were aware they could only share information regarding an allegation of sexual abuse to those who are on a need-to-know basis. In addition, interviews with eight random DOs confirmed the officers struggled with articulating avenues available to them for reporting an allegation of sexual abuse outside the chain of command. Several responded they could call CCSO, while others said they would more than likely call the OIG. An interview with the AFOD indicated he was knowledgeable regarding his reporting responsibilities when the allegation includes a vulnerable adult. The Auditor reviewed two investigative files and confirmed the allegations did not involve a vulnerable adult. The Auditor reviewed PISPC policy 4.5.13 and confirmed the policy has been submitted and approved by the Agency. The facility does not house juveniles.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy does not include an avenue in which staff can make a report of sexual abuse outside the chain of command. Interviews with eight random DOs confirmed the officers struggled with articulating an avenue available to them to report an allegation of sexual abuse outside the chain of command. To become compliant, the facility must revise PISPC policy 4.5.13, to include a method by which staff can report an allegation of sexual abuse outside of their chain of command. Once revised, the facility must submit documentation to confirm all staff have received training on the revised policy.

Corrective Action Taken:

The facility submitted a revised 4.5.13 policy which states, "An employee not wishing to address their allegation of sexual abuse to a supervisor, he/she may report outside the chain of command by filing a complaint or report by contacting the ICE Office of Professional Responsibility Integrity Coordination Center." In addition, the policy includes a 1-800 number, an email address and a mailing address. The facility submitted 10 employee acknowledgments which state, "The employee acknowledges receipt, review and comprehensive understanding of the DHS/ICE-ERO Policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention with instructions, in relation to facility Policies and Procedures set forth. Furthermore, the employee understands methods by which staff can report an allegation of sexual abuse outside of their chain of command." A review of the acknowledgements confirm staff from all disciplines have been trained, to include medical staff, security staff, and administrative staff. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f): PISPC policy 4.5.13 states, "Detainees will be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault. Any sanctions imposed will be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. The facility holding detainees in custody will have a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure. If a detainee is mentally disabled or mentally ill but competent, the disciplinary process will consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The facility will 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 or assault made in good faith based upon a reasonable belief that the alleged conduct occurred will not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The lead Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center has no record demonstrating that disciplinary sanctions were imposed on a detainee found to have engaged in sexual abuse during the reporting period." An interview with the facility Disciplinary Officer indicated the facility does have a formal disciplinary process with progressive levels of review, appeals, and documentation procedures. An interview with the facility Disciplinary Officer further indicated disciplinary hearings are conducted by a Disciplinary Panel, which consists of a facility Captain, a Lieutenant, and a facility Detention Officer. In addition, in an interview with the Disciplinary Officer it was indicated a detainee would not be disciplined for sexual contact with staff unless there is a finding the staff member did not consent or disciplined for allegations made in good faith and a detainee's mental illness and how it may have contributed to the behavior is considered during the disciplinary process. The Auditor reviewed two sexual abuse allegation investigation files and confirmed both investigative findings were unsubstantiated; however, each file had disciplinary documents which confirmed the alleged perpetrator had been disciplined at the time of the allegation and not based on a substantiated finding. The Auditor conducted a follow-up interview with the Disciplinary Officer and confirmed the facility's practice was to initiate a misconduct report for the highest charge available, assault which includes sexual abuse and not following an administrative or criminal finding the detainee engaged in sexual abuse 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 two sexual abuse allegation investigation files and confirmed both investigative findings were unsubstantiated; however, each file had disciplinary documents which confirmed the alleged perpetrator had been disciplined at the time of the

allegation and not based on a substantiated finding. The Auditor conducted a follow-up interview with the Disciplinary Officer and confirmed the facility's practice was to initiate a misconduct report for the highest charge available, assault which includes sexual abuse and not following an administrative or criminal finding the detainee engaged in sexual abuse as required by subsection (a) of the standard. To become compliant, the facility must develop, and implement, a process to ensure detainees are subject to disciplinary sanctions pursuant to formal disciplinary process following an administrative or a criminal finding the detainee engaged in sexual abuse. Once implemented the facility must submit documentation to confirm all applicable staff, to include all staff involved in the disciplinary process, receive training on the implemented procedure. If applicable, the facility must submit all sexual abuse allegation investigation files, and the corresponding disciplinary documentation, to confirm the alleged detainee perpetrator is not issued a misconduct report unless the alleged sexual abuse is substantiated.

Corrective Action Taken:

The facility has implemented a revised memorandum suspending the disciplinary proceedings for Assaulting any person (includes sexual assault). The memorandum states, "This memorandum is to inform you that on (date), a noncitizen (name) Institutional disciplinary proceedings have been suspended pending disposition of the administrative or criminal investigation," The facility submitted an additional 11 employee acknowledgements which states, "The employee acknowledges receipt, review and comprehensive understanding of the DHS/ICE-ERO Detainee Disciplinary Sanctions and Process with instructions, in relation to Disciplinary Policies and Procedures set forth. Furthermore, the employee understands the importance of ensuring detainees are subject to disciplinary sanctions pursuant to formal disciplinary process following an administrative or criminal finding the detainee engaged in sexual abuse." A review of the acknowledgements confirms the acknowledgements included supervisory staff within the facility. The facility submitted one sexual abuse allegation investigative file. A review of the file confirmed the allegation of sexual abuse was found to be unsubstantiated; however, based on a finding of horseplay, and not due to perpetrating sexual abuse, the facility subjected the detainee perpetrator to the disciplinary process. The facility submitted one substantiated sexual abuse allegation file which included a detainee perpetrator. The Auditor reviewed the submitted file and confirmed the detainee perpetrator was not issued a behavior report prior to the outcome of investigation; however, prior to substantiating the allegation the detainee perpetrator was released; and therefore, no disciplinary action was taken. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

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

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

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "If screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff will, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee will receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee will receive a mental health evaluation no later than seventy-two (72) hours after the referral." IHSC Directive 03-10 states, "Behavioral health referrals are made in accordance with the IHSC Behavioral Health Services Guide. If a detainee discloses a history of sexual victimization or abuse during a medical or mental health intake screening, whether it occurred in an institutional setting or in the community, a referral to mental health or an MLP should be made immediately. If, at any time during the intake screening or review, a detainee requests, or there appears to be, a need for mental health services, the nurse will notify the Health Services Administrator (HSA) as soon as possible, or within 24 hours." Interviews with a Classification Officer and an Intake Officer indicated if during the initial risk assessment, a detainee discloses previous sexual abuse or has perpetrated sexual abuse, intake staff will complete the "Detainee requires Medical/Mental Health Assessment" on the Detainee Classification Risk Assessment form. The lead Auditor reviewed the facility

Detainee Classification Risk Assessment, and confirmed it includes a section to note if a detainee requires a Medical/Mental Health Assessment. A review of the facility Detainee Classification Risk Assessment further confirms the form states, "(Referral must be made within 48 hours of intake. Shift Supervisors must be notified prior to housing.)" In an interview with the Classification Officer, it was indicated once the form is completed a phone call is immediately made to medical staff to let them know a referral needs to be completed. In an interview with the Intake Officer, it was indicated if a referral to medical or mental health staff is needed Intake staff will notify medical staff working in the intake. During the on-site audit, although requested, the facility could not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse based on the Detainee Classification Risk Assessment; and therefore, the lead Auditor could not confirm referrals to medical and/or mental health were being made immediately after being identified by the initial risk assessment pursuit to 115.41. An interview with the AHSA indicated, if a referral is needed, staff will send an email to the medical assistant and other relevant staff, to include but not limited to the AHSA, and the PSA Coordinator/Compliance Manager. An interview with the AHSA further indicated, once the medical assistant receives the email a telephone encounter is entered into the medical computer system which notifies medical staff a detainee has been identified as a victim or abuser and the detainee will be seen by medical staff within two working days. An interview with a LCSW indicated once the telephone encounter has been initiated, she will see the detainee the same day or the following day; however, no later than 72 hours after the referral. During the on-site audit, although requested, the facility did not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse until medical provided a medical roster which included detainees who had been identified as sexual aggressors or victims of sexual abuse based on the initial medical assessment conducted during the intake process. However, as the medical roster was not provided until the exit interview the Auditor was unable to review medical and mental health files to confirm, a referral had been immediately initiated at intake or medical and mental health staff-initiated follow-ups with the detainees in the timeframes required by subsections (b) and (c) of the standard.

Corrective Action:

The facility is not in compliance with subsection (a), (b), and (c) of the standard. The lead Auditor reviewed the facility Detainee Classification Risk Assessment and confirmed the form requires, "Referral must be made within 48 hours of intake." During the on-site audit, although requested, the facility could not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse based on the Detainee Classification Risk Assessment; and therefore, the lead Auditor could not confirm referrals to medical and/or mental health were being made immediately after being identified by the initial risk assessment pursuit to 115.41. During the on-site audit, although requested, the facility did not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse until medical provided a medical roster which included detainees who had been identified as sexual aggressors or victims of sexual abuse based on the initial medical assessment conducted during the intake process. However, as the medical roster was not provided until the exit interview the Auditor was unable to review medical and mental health files to confirm, a referral had been immediately initiated at intake or medical and mental health staff-initiated follow-ups with the detainees in the timeframes required by subsections (b) and (c) of the standard. To become compliant, the facility must implement a practice which requires a detainee who has experienced prior sexual victimization or perpetrated sexual abuse, is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate and when a referral for medical follow-up is initiated, the detainee receives a health evaluation no later than two (2) working days from the date of assessment or when a referral for mental health follow-up is initiated, the detainee receives a mental health evaluation no later than seventy-two (72) hours after the referral. Once implemented, the facility must submit documentation which confirms all applicable staff, to include Intake, Classification, medical, and mental health, have received training on the implemented practice. In addition, the facility must submit 10 detainee files, to include a detainee has been identified as a sexual aggressor or sexual abuse victim, and the corresponding medical and mental health records to confirm a detainee who has experienced prior sexual victimization or

perpetrated sexual abuse, was immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate and when a referral for medical follow-up is initiated, the detainee receives a health evaluation no later than two (2) working days from the date of assessment or when a referral for mental health follow-up is initiated, the detainee receives a mental health evaluation no later than seventy-two (72) hours after the referral.

Corrective Action Taken:

The facility submitted revised Detainee Classification Risk Assessment. The Auditor reviewed the revised risk assessment and confirmed the assessment requires staff to submit an immediate referral to medical/mental health if the detainee identifies as having a history of sexual abuse or perpetrating sexual abuse. The facility submitted 10 staff training memos which indicated staff have received training on the implemented Detainee Classification Risk Assessment The facility submitted 10 detainee initial risk assessments. The Auditor reviewed the submitted risk assessments and confirmed 1 initial assessment required an immediate referral to medical/mental health as the detainee identified as previously experiencing sexual abuse. The Auditor reviewed the detainee initial intake and confirmed the initial intake documents an immediate referral was made to medical/mental health. In addition, the Auditor reviewed the corresponding medical and mental health records and confirmed the detainee was immediately referred to mental health during medical intake due to a history of sexual abuse and was seen by mental health for a follow-up within 72 hours as required by subsection (c) of the standard. The facility did not submit any intake screenings which include detainees who had a history of perpetrating sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in substantial 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 2/14/2025

Auditor's Signature & Date

(b) (6), (b) (7)(C) 3/3/2025

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 2/28/2025

Assistant Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

AUDIT DATES			
From:	6/11/2024	**To:**	6/13/2024
AUDITOR INFORMATION			
Name of auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Harlingen
Field Office Director:	Miguel Vergara
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1717 Zoy Street Harlingen, TX 78550
INFORMATION ABOUT THE FACILITY BEING AUDITED	
Basic Information About the Facility	
Name of facility:	Port Isabel SPC
Physical address:	27991 Buena Vista Boulevard Los Fresnos, Texas 78566
Telephone number:	(956) 547-1700
Facility type:	Service Processing Center
PREA Incorporation Date:	3/18/2015

Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Assistant Field Office Director (AFOD)
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	956-547-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	956-370-(b) (6), (b)

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of Port Isabel Service Processing Center (PISPC) was conducted June 11, 2024, through June 13, 2024, by U.S. Department of Justice (DOJ) and DHS Certified PREA Auditors Robin M. Bruck (lead Auditor) and William Pierce both employed by Creative Corrections, LLC. The lead Auditor was provided guidance and review during the audit report writing and review process by U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C) both DOJ and DHS Certified PREA Auditors. The PM's role is to provide oversight for the ICE PREA audit process and liaison with ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility compliance with the DHS PREA Standards. PISPC is owned by ICE and operated by Akima Infrastructure Protection (AIP). PISPC is in Los Fresnos, Texas. The audit was the third DHS PREA audit for the facility and includes a review of the period between June 13, 2023, and June 13, 2024.

The facility has a design capacity of 1200. On the first day of the on-site audit, the detainee population was 1032 adult male detainees with low or medium security classification. The facility does not house female detainees, juvenile detainees, or family units. The facility provides a staging area where female detainees are held pending transport to another facility; and therefore, are not housed at the facility. Detainees housed at the facility face local charges, are going through the deportation, or are awaiting deportation. The average length of stay is approximately 18 days. The top three nationalities housed at PISPC are Guatemala, Honduras, and Valenzuela.

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, all documentation, policies, and the facility PAQ were reviewed by the Auditor. In addition, the Auditor reviewed the Agency website (www.ice.gov/prea) and confirmed the facility website (https://www.ice.gov/detain/detention-facilities/port-isabel-service-processing-center) links to the Agency website. The main policy that governs PISPC's sexual abuse prevention, intervention, and response efforts is policy 4.5.13 Sexual Abuse and Assault Prevention and Intervention.

An entrance briefing was held in the PISPC's conference room on Tuesday, June 11, 2024, at 8:15 a.m. The ICE ERAU TL, (b) (6), (b) (7)(C), opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C), TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), Facility Health Program Manager (FHPM), ICE Health Service Corps (IHSC)
(b) (6), (b) (7)(C), Nurse Manager (NM), IHSC
(b) (6), (b) (7)(C), Assistant Nurse Manager (ANM), IHSC
(b) (6), (b) (7)(C), Assistant Health Service Administrator (AHSA), IHSC
(b) (6), (b) (7)(C), Supervisory Detention Deportation Officer, (SDDO), PSA Compliance Manager, ICE/ERO
(b) (6), (b) (7)(C), Assistant Facility Director (AFD), AIP
(b) (6), (b) (7)(C), Assistant Field Office Director (AFOD), ICE/ERO
(b) (6), (b) (7)(C), PREA Investigator, AIP
(b) (6), (b) (7)(C), Physical Security Inspector, AIP

(b) (6), (b) (7)(C), Facility Director (FD), AIP
(b) (6), (b) (7)(C), Chief of Security (COS), AIP
(b) (6), (b) (7)(C), Physical Security, AIP
(b) (6), (b) (7)(C), Quality Assurance Manager (QAM), AIP
(b) (6), (b) (7)(C), Quality Assurance (QA), AIP
(b) (6), (b) (7)(C), QA, AIP
Robin Bruck, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC
William Pierce, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC

The Auditor introduced herself and provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained the audit process is designed to not only assess compliance through written 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 tour of the facility was conducted by the Auditors and key staff from PISPC and ICE. All areas of the facility where detainees are afforded the opportunity to go were observed to include housing units, program areas, booking/intake, recreation, visitation, laundry, food service, library, and medical areas. In addition, the Auditor observed the control center, sally port, and administrative offices. During the on-site audit, the lead Auditor made visual observations (b) (7)(E) The lead Auditor observed PREA information in all common areas of the facility and near the detainee telephones in English and Spanish which included the DHS-prescribed sexual assault notice, the Detention and Reporting Information Line (DRIL) poster, DHS Office of Inspector General (OIG) poster, the Rape Abuse, and Incest National Network (RAINN) poster, the facility PREA Hotline number, Sexual Assault Victim Service Provider flyer, and information for contacting consular officials. During the on-site audit, the Auditor tested the telephone numbers provided for the DRIL and DHS OIG and confirmed they were in good working order; however, the Auditor utilizing a detainee pin number, tested the number posted for the PISPC PREA Hotline by leaving a message with instructions to immediately inform the PSA Compliance Manager or the Audit Team once it had been received; however, neither PSA Compliance Manager or the Audit Team received a response.

(b) (7)(E). (b) (7)(E). (b) (7)(E) (b) (7)(E)

The PISPC PAQ indicates the facility employs 599 employees who may have reoccurring contact with detainees, consisting or 428 security staff, (329 males and 99 females); 80 medical staff (14 IHSC, 6 Government Service, 60 STG), and 5 contracted STG mental health staff. Additional staff include AGS food service. Maintenance services are provided by Chenega, Commissary staff by Keefe Commissary Network, and janitorial staff by Muvagi. Twenty-six volunteers employed by Jesuit Refugee Services provide religious services. Correctional staff work in three shifts 0700-1500, 1500-2300, 2300-0700. The facility provided the lead Auditor with staff rosters for random selection of interviews and file reviews. During the on-site audit, the Auditors interviewed 25 staff members to include the AFOD, FD, SDDO/PREA Compliance Manager, facility PREA Investigator/Retaliation Monitor/Disciplinary Officer, Classification Officer (CO), Intake Officer, Human Resource Manager (HRM), Licensed Clinical Social Worker (LCSW), AHSA, Shift

Commander/Staff Member who conducts Unannounced Rounds, Incident Review Team member, Grievance Officer (GO), 5 random Compliance Team members, and 8 random Detention Officers (DOs)/facility 1st responders. In addition, the lead Auditor interviewed one Licensed Clinical Social Worker (LCSW) contracted through STG. The Auditors did not conduct an interview with a volunteer as there were no volunteers who entered the facility during the hours the Auditors were on-site. All interviews were conducted in a private setting allowing for confidentiality for those participating in the interview process.

The support Auditor interviewed 30 detainees to include 26 limited English Proficient (LEP), 1 transgender detainee, 2 disabled detainees, and 1 detainee who reported sexual abuse. LEP interviews were conducted with the use of a language line through Language Services Associates (LSA) provided by Creative Corrections, LLC. All interviews were conducted in a private setting allowing for confidentiality for those participating in the interview process.

The facility PAQ indicated there are six investigators at the facility. The lead Auditor reviewed the facility PREA Allegation Spreadsheet and confirmed the facility had two detainee-on-detainee PREA allegations closed during the reporting period both resulting in a finding of unsubstantiated.

An exit briefing was conducted on Thursday, June 13, 2024, at 11:30 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
(b) (6), (b) (7)(C), SDDO/PSA Compliance Manager, ICE/ERO
(b) (6), (b) (7)(C), FHPM, IHSC
(b) (6), (b) (7)(C), ANM, IHSC
(b) (6), (b) (7)(C), AHSA, IHSC
(b) (6), (b) (7)(C) AFD, AIP
(b) (6), (b) (7)(C), PREA Investigator, AIP
(b) (6), (b) (7)(C), Physical Security Inspector, AIP
(b) (6), (b) (7)(C), FD, AIP
(b) (6), (b) (7)(C), COS, AIP
(b) (6), (b) (7)(C), Physical Security, AIP
(b) (6), (b) (7)(C), QAM, AIP
(b) (6), (b) (7)(C), QA, AIP
(b) (6), (b) (7)(C), QA, AIP
Robin Bruck, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC
William Pierce, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC

The lead Auditor spoke briefly and informed those present it was too early in the process to formalize a determination of compliance on each standard. The lead Auditor would review all documentation, interview notes, file review notes, and on-site observations to determine compliance. The lead 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 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: 0

Number of Standards Met: 25

- §115.17 - Hiring and promotion decisions.
- §115.18 - Upgrades to facilities and technologies.
- §115.21 - Evidence protocols and forensic medical examinations.
- §115.31 - Staff training.
- §115.32 - Other training.
- §115.34 - Specialized training: Investigations.
- §115.35 - Specialized training: Medical and mental health care.
- §115.52 - Grievances.
- §115.62 - Protection duties.
- §115.63 - Reporting to other confinement facilities.
- §115.64 - Responder duties.
- §115.65 - Coordinated response.
- §115.66 - Protection of detainees from contact with alleged abusers.
- §115.67 - Agency protection against retaliation.
- §115.68 - Post-allegation protective custody.
- §115.71 - 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.
- §115.82 - 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 reviews.
- §115.87 - Data collection.
- §115.201 - Scope of audits.

Number of Standards Not Met: 15

- §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.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.43 - Protective custody.
- §115.51 - Detainee reporting.
- §115.53 - Detainee access to outside confidential support services.
- §115.54 - Third-party reporting.
- §115.61 - Staff reporting duties.

- §115.78 - Disciplinary sanctions for detainees.
- §115.81 - Medical and mental health assessments; history of sexual abuse.

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: Does Not Meet Standard

Notes:

(c): PISPC policy 4.5.13 states, "It is the policy of the Port Isabel Detention Center (PISPC) to ensure the safety and well-being of detainees housed at this facility. It is the responsibility of Immigration and Customs Enforcement (ICE) to protect detainees from sexual abuse, sexual harassment, personal injury and/or abuse. All sexual conduct between detainees, detainees and staff, volunteers, or contract personnel, regardless of consensual status, is strictly prohibited and subject to administrative, disciplinary, and criminal sanctions. Therefore, ICE has a standard of zero-tolerance for any form of said sexual activity. All PISPC staff, contract personnel, and volunteers are trained in the identification and reporting procedures of sexual assault or abuse." In review of the policy the Auditor confirmed the policy includes definitions of sexual abuse and general PREA definitions and 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 security inspections, mandatory reporting protocols, investigations, and support from victim advocates. During the on-site audit, the lead Auditor observed the DHS-prescribed sexual abuse and assault awareness notice posted in the housing units and programming areas of the facility. Interviews with eight random DOs confirmed they were knowledgeable regarding the facility and Agency zero-tolerance policy. The lead Auditor reviewed PISPC and confirmed the policy was approved by the AFOD.

(d): PISPC policy 4.5.13 states, "The Assistant Field Office Director (AFOD) will designate an ICE manager or designee as the SAAPI Program Coordinator. ICE Health Service Corps (IHSC) has also designated a staff member to assist the program coordinator. These program coordinators will be responsible for: assisting with the development of the written policies and procedures for the SAAPI Program and keeping them current; assisting with the development of initial and ongoing training protocols; making the SAAPI protocol available to the public by posting in the lobby entrance; serving as a liaison with other agencies; coordinating the gathering of statistics and reports on allegations of sexual abuse or assault, as detailed below in the section on Tracking Incidents of Sexual Abuse and Assault; reviewing the results of every investigation of sexual abuse and conduct an annual review of all investigations in compliance with the Privacy Act to assess and improve prevention and response efforts; and reviewing facility practices to ensure the required levels of confidentiality are maintained." The Auditor reviewed the facility Organizational Chart and confirmed the PSA Coordinator/PSA Compliance Manager is in a position of authority. Interviews with the AFOD and the PSA Coordinator/PSA Compliance Manager indicated the PSA Coordinator is assigned to another facility within the area and does not spend sufficient time at the facility; however, will visit the facility at least once during a two-week period. An interview with the PSA Coordinator/PSA Compliance Manager confirmed she serves as the point of contact for the Agency PSA Coordinator and has the authority necessary to oversee the facility's efforts to comply with the sexual abuse prevention and intervention policies and procedures; however, the Auditor could not confirm she has the time or an understanding of the PREA standards and their subsections, to efficiently assess, implement, and improve the facility's prevention and response to sexual abuse. During the on-site audit, any concerns the Auditor had, were discussed, and answered by the AIP Compliance Team; however, although, the team had knowledge and could articulate the policies and procedures established to ensure compliance with some of the PREA standards, their lack of knowledge for all the PREA standards to ensure compliance was evident.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. The Auditor could not confirm the PSA Coordinator/PSA Compliance Manager had the time or an understanding of the PREA standards and all subsections, to efficiently assess, implement and improve the facility's prevention and response to sexual abuse. Interviews with the AFOD and the PSA Coordinator/PSA Compliance Manager indicated the PSA Coordinator is assigned to another facility within the area and does not spend sufficient time at the facility; however, will visit the facility at least once during a two-week period. During the on-site audit, any concerns the Auditor had, were discussed, and answered by the AIP Compliance Team; however, although, the team had knowledge and could articulate the policies and procedures established to ensure compliance with some of the PREA standards, their lack of knowledge for all the PREA standards to ensure compliance was evident. To become compliant, the facility shall ensure the designated PSA Compliance Manager has sufficient time within the facility to oversee the facility's efforts to comply with the sexual abuse prevention and intervention policies and procedures.

§115.13 - Detainee supervision and monitoring.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "PISPC will ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The AFOD will determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, PISPC will take into consideration generally accepted detention and correctional practices, any 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 as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors." PISPC currently employs 599 staff and contractor staff, which includes 26 AIP Management, 425 security staff (326 males and 99 females), 80 medical staff (14 IHSC, 6 Government Service, 60 contracted STG), and 5 contracted STG mental health. Additional staff include AGS food service. Maintenance services are provided by Chenega, Commissary staff by Keefe Commissary Network, and janitorial staff by Muvagi. Twenty-six volunteers employed by Jesuit Refugee Services provide religious services. Correctional staff work in three shifts 0700-1500, 1500-2300, 2300-0700. In addition, (b) (7)(E) (b) (7)(E). During the on-site audit, the Auditor reviewed the facility comprehensive supervision guidelines and confirmed they are reviewed, and updated if needed, on an annual basis and each staff member is required to review the post order for their assigned post daily and confirm their review by signature in the post order book. During the on-site audit, the Auditors observed there were no notable "blind spots" and there was adequate staffing throughout all areas of the facility. An interview with the FD indicated the facility has adequate staffing levels which are determined by the contract. An interview with the FD further indicated the staffing plan and the need for video monitoring are reviewed monthly; however, the FD could not articulate, how or if, the review takes into consideration the 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 as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors. During the on-site audit, with the assistance of the FD, the lead Auditor reviewed the contract; however, could not confirm the contract took into consideration all elements required by subsection

(c) of the standard.

(d): PISPC policy 4.5.13 states, “Frequent unannounced security inspections will be conducted to identify and deter sexual abuse of detainees. Inspections will occur on night as well as day shifts. Staff is prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility.” An interview with the FD indicated all supervisors are required to conduct unannounced security inspections on each shift which are documented in red ink in the housing unit logbooks. An interview with a Shift Commander confirmed he conducts unannounced security inspections within the facility, was very knowledgeable, and could articulate unannounced security inspections are conducted to deter staff and detainees from participating in sexual abuse. An interview with a Shift Commander further confirmed if a staff member was found alerting other staff of the unannounced security inspections they could face disciplinary action. During the on-site audit, the Auditor reviewed the housing unit logbooks and confirmed unannounced security inspections were being conducted daily, on every shift, and at irregular times.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. An interview with the FD indicated the facility has adequate staffing levels which are determined by the contract. An interview with the FD further indicated the facility staffing plan is reviewed monthly; however, the FD could not articulate, how or if, the review takes into consideration the 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 as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors. During the on-site audit, with the assistance of the FD, the lead Auditor reviewed the contract; however, could not confirm the contract took into consideration all elements required by subsection (c) of the standard. To become compliant, the facility must submit documentation which confirms the facility took into consideration when determining adequate staffing levels and the need for video monitoring, generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relevant factors including, but not limited to, the length of time detainees spend in Agency custody.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable

Notes:

(a)(b)(c)(d): The Auditor reviewed a memorandum to the file which states, “Port Isabel Detention Center does not detain juveniles or family units.” During the on-site audit, the lead Auditor confirmed through observation 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: Does Not Meet Standard

Notes:

(b)(c)(d)(e)(f): PISPC policy 4.5.13 states, “Pat-down searches of male detainees by female staff will not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Pat-down searches of female detainees by male staff will not be conducted unless in exigent circumstances. All pat-down searches by staff of the opposite gender will be documented. Strip searches or visual body cavity searches by staff of the opposite gender will not be conducted

except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. All strip searches and visual body cavity searches will be documented." The lead Auditor reviewed two memorandums to the file which state, "Port Isabel Detention Center staff members did not conduct any cross-gender pat-down searches during the audit period" and "Port Isabel Detention Center staff members did not conduct any strip searches or visual body cavity searches during the audit period." Interviews with eight random DOs confirmed they were aware cross-gender pat-down searches, strip searches, cross-gender strip searches, or visual body cavity searches are strictly prohibited and are not to be conducted at the facility; however, if there are exigent circumstances requiring a cross gender search, it would be documented on a Record of Search form and an Incident Report would be completed. An interview with eight random DOs further indicated they have not witnessed or participated in a cross-gender pat-down search, a cross gender strip search, or a visual body cavity search during their employment with the facility. Interviews with 28 random detainees confirmed they had been subjected to a pat-down search conducted by a male officer; however, interviews with 2 additional detainees confirmed they could not remember if they had ever received a pat-down searched at the facility. Interviews with 30 random detainees confirmed they had not been strip searched at the facility. During the on-site audit, the lead Auditor observed a pat-down search of a detainee and confirmed the pat-down search was conducted by a male DO. The facility does not house juveniles.

(g): PISPC policy 4.5.13 states, "Detainees will be able 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 and hold room checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender will announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." Informal interviews with 5 random Compliance Team members indicated male officers are assigned posts in the male housing units to avoid cross-gender viewing allowing detainees to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender. During the on-site audit, the Auditors observed toilet and shower areas within all housing unit pods, as well as toilet areas throughout the facility and confirmed holding cells within visitation, had toilets which could be viewed from the windows, outside the holding cell; however, prior to the Auditors completing the on-site audit, the facility had installed a film over the windows to prevent viewing of the toilet from the windows. During the on-site audit the Auditors further observed in the shower areas of all housing unit pods, there was a half-wall which provided privacy for detainees while showering; however, the shower's dressing area was approximately three and half feet between the changing area and the shower area, leaving the detainee in a state of undress and visible from the large windows outside each pod which can be observed by female staff assigned to the housing unit control centers. In addition, during the on-site audit, (b) (7)(E) The Auditors further observed signage outside each housing unit advising staff of the opposite gender to announce themselves prior to entering the housing units. Interviews with eight random DOs indicated female staff announce their presence if there is a need for them to enter the housing units which was observed by the Auditors during the on-site audit. Interviews with 30 random detainees confirmed they are made aware of female staff prior to them entering the pod; however, female staff did not usually enter the housing units.

(h): PISPC is not designated as Family Residential Centers; and therefore, subsection (h) is not applicable.

(i)(j): PISPC policy 4.5.13 states, "PISPC will not search or physically examine a detainee for the sole purpose of determine the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. All pat-down searches will be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and procedures

described in PISPC Policy 3.1.18 “Searches,” including officer safety.” The lead Auditor reviewed the ICE Cross-Gender, Transgender, and Intersex Searches training curriculum and confirmed the training curriculum includes, “All searches shall be performed in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety.” Interviews with eight random DOs indicated each staff member is required to complete annual training in the proper procedures for conducting pat-down searches or cross-gender pat-down searches. Interviews with eight random DOs further confirmed they are notified if a transgender, or intersex, detainee will be arriving at the facility prior to the detainee’s arrival at the facility; however, if a detainee’s gender is unknown, they would consult with medical staff. In addition, interviews with eight random DOs further confirmed they have not witnessed or conducted a search of a detainee for the sole purpose of determining the detainee’s gender while employed at the facility. An interview with a transgender detainee, indicated she did not believe she had been subjected to a search for the sole purpose to determine her genital status. An interview with a transgender detainee further indicated staff has been very professional and has allowed her to choose the gender of the officer who will conduct a pat-down search prior to performing the search. The Auditor reviewed 11 relevant staff files and confirmed each staff member had completed the ICE Cross-Gender, Transgender, and Intersex Search training.

Corrective Action:

The facility is not in compliance with subsection (g) of the standard. In the shower areas of all housing unit pods, the Auditor observed a half-wall which provided privacy for a detainee while showering; however, the shower area also has a dressing area on the opposite side of the shower with a built-in bench and hooks for the detainee to dress, undress, and hang their clothing to avoid the clothing getting wet from the shower water. However, there is approximately three and half feet between the changing area and the shower area, in which a detainee must walk to get to the shower, leaving the detainee’s naked body exposed and visible from the large windows outside each pod in the secured area of the housing unit which is visible from the housing unit control center where female staff are assigned. To become compliant, the facility must submit documentation to confirm the facility implemented a practice to ensure detainees are able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender.

<u>§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.</u>

Outcome: Does Not Meet Standard

Notes:

(a)(b): PISPC policy 4.5.13 states, “PISPC will take appropriate steps to 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 agency’s efforts to prevent, detect, and respond to sexual abuse and assault. Such steps will include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, by: Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication. PISPC will take steps to ensure meaningful access to all aspects of the agency’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 interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary.” Interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the facility’s sexual abuse prevention and response. Interviews with 5 random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated all detainees are provided the ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the facility Detainee Handbook Local Supplement and will

watch a PREA orientation video. In addition, interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated accommodations are made to ensure effective communication is established with detainees to include, but not limited to, the use of a teletypewriter (TTY) or Telecommunication device for the deaf (TDD) phone, video remote interpreting via I-pad, a hearing aid/amplifier, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated for detainees who have limited reading skills, or are limited English proficient (LEP), staff will utilize the facility language, or a staff interpreter, who is proficient in the detainee's preferred language line, to interpret the information. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated if a detainee is blind, the staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure the detainee understands the PREA material provided. During the on-site audit, the lead Auditor observed the ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet were readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese. In addition, the Auditor observed the facility Detainee Handbook Local Supplement, and confirmed it was readily available in 14 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. The lead Auditor reviewed the facility supplemental handbook and confirmed the handbook does not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. In an interview with 5 random Compliance Team members, it was indicated in addition to the facility supplemental handbook, the facility also provides detainees PREA information in a script available in English and Spanish and for those detainees whose preferred language is not English or Spanish, the script is read to the detainees with the use of the facility language line or a staff interpreter. Prior to the on-site audit, the Auditor reviewed the script and confirmed the script advised detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script, which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional information noted in the facility supplemental handbook. The lead Auditor reviewed 22 detainee files and confirmed 7 of the files included documentation to confirm detainees were provided with ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, the facility supplemental handbook, and the video; however, the video is not available in a manner all detainees can understand. A review of the detainee files further confirmed the documentation reviewed did not confirm the detainee acknowledged he had been provided the Detainee Education for Intake Staff Script. Interviews with 30 detainees confirmed they had received the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility supplemental handbook in their preferred language; however, did not confirm they had watched the PREA video or the received the Detainee Education for Intake Staff Script in a manner they could understand.

(c): PISPC policy 4.5.13 states, "In matters relating to allegations of sexual abuse, the facility will employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. PISPC will provide detainees with

disabilities and detainees with limited English proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services will be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE/ERO determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse or assault, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse or assault." Interviews with eight random DOs indicated they could utilize another detainee for interpretation, if the detainee victim expressed a preference and the other detainee was not a witness, the abuser or someone with a significant relationship to the abuser. Interviews with eight random DOs further indicated they would seek the approval from their supervisor and the Agency prior to utilizing another detainee to interpret in matters related to sexual abuse and the approval and the circumstances surrounding the use of another detainee would be documented in an Incident Report and provided to the Investigator. The Auditor reviewed two sexual abuse allegation investigation files and confirmed there were no instances which included the use of a detainee for interpretation during the investigation.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script, which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional information noted in the facility supplemental handbook. The lead Auditor reviewed 22 detainee files and confirmed 7 of the files included documentation to confirm detainees were provided with ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, the facility supplemental handbook, and the video; however, the video is not available in a manner all detainees can understand. A review of the detainee files further confirmed the documentation reviewed did not confirm the detainee acknowledged he had been provided the Detainee Education for Intake Staff Script. To become compliant, the facility must implement a practice to ensure all detainees have meaningful access to the facility's efforts to prevent, detect, and respond to sexual abuse. Once implemented the facility must submit documentation which confirms all Intake and Classification staff have received training on the implemented practice. The facility must submit 10 detainee files, to include if applicable, detainees who do not speak English or Spanish, who arrive during the corrective action plan (CAP) period to confirm detainees have meaningful access to the facility's efforts to prevent, detect, and respond to sexual abuse, to include, but not limited to, information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services.

§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. PISPC policy 4.5.13 states, “The agency or facility will implement hiring and promotion practices, and devise methods to collect and document information that will demonstrate compliance with the requirements reflected in the standard. Confirmation that these practices and/or policies are being implemented will usually be captured in employment applications and interview notes, personnel reviews, and evidence of criminal background and records checks. Achieving compliance with the standard may entail reviewing, updating, and incorporating the requirements into current practices and policies, and ensuring the staff responsible for hiring and promoting are familiar with the standard and these changes. The agency or facility may not hire or promote any employee or enlist the services of any contractor or volunteer who may have contact with detainees, which includes anyone who provides recurring services to the agency or facility, if the agency or facility knows that person to have a history of sexual abuse described in the standard. That includes: • Having engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (this means there is some administrative adjudication substantiating that the sexual abuse occurred in an institution, defined as state facilities for people who are mentally ill, disabled, or retarded, or chronically ill or handicapped; residential care or treatment facilities for juveniles; and facilities that provide skilled nursing, or intermediate or long-term care, or custodial or residential care); • Having been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; • Having been civilly or administratively adjudicated to have engaged in any of the activity described above. The agency or facility is required to consider any incidents of sexual harassment in determining whether to hire, promote, or contract with anyone who may have contact with detainees. This consideration must be formal and documented in each case in a manner that an auditor can review. Prior to hiring new employees or enlisting contractors who may have contact with detainees, the agency or facility must conduct a criminal background records check, which at a minimum means the agency or facility must access the standardized criminal records databases maintained and widely used by law enforcement agencies. For prospective employees, the agency must also make best efforts to contact all previous institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of sexual abuse. The agency or facility must directly ask all applicants for a new position or a promotion who may have contact with detainees about any previous incidents of institutional or community sexual abuse in interviews or written applications. The agency must take similar steps with employees up for review by directly asking them about any prior incidents in interviews or written self-evaluations. In addition to these measures, employees must be required by the agency or facility to affirmatively disclose any sexual misconduct. The presumptive disciplinary action for failing to disclose information regarding prior sexual misconduct or providing false information will be termination or withdrawal of an offer of employment, as appropriate. Unless prohibited by law, the agency is required to provide information regarding substantiated incidents of sexual abuse or sexual harassment involving a former employee when contacted by a new prospective employer of that person. This requirement aims to address the fact that staff may resign from one correctional facility (in lieu of being terminated) because of an incident or investigation of staff sexual abuse or harassment and seek employment at another correctional facility.” An interview with the HRM indicated all potential employees are required to complete an application on-line and if qualified for the position, the perspective employee, or staff contractor, would be set up for an interview. An interview with the HRM further indicated if based on the interview the prospective employee is determined to be suitable for employment, the potential employee would complete the DHS 6 Code Federal Regulation Part 115 form and the facility will submit his/her name to the ICE Personnel Security Division (PSD) for completion of a background

investigation. In addition, an interview with the HRM indicated potential staff contractors would follow the same process; however, their application would be handled through the ICE Contracting Officer Representative (COR) and not the Human Resource Office, and volunteers would complete the DHS 6 Code of Federal Regulations Part 115 and be subjected to a background check. An interview with the HRM further indicated background checks are completed by ICE PSD every five years for each person working in the facility. In an addition, an interview with the HRM indicated if a staff member is promoted the promotion offer is sent to the COR who will ensure the staff member completes a DHS 6 Code of Federal Regulations Part 115 form prior to a promotion. An interview with the HRM further indicated information on substantiated allegations of sexual abuse involving a former staff member would be provided upon request from an institutional employer the staff member has applied to work. The lead Auditor reviewed the DHS 6 Code of Federal Regulations Part 115 form and confirmed the form asks, "Have you ever been found to have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution, or convicted of engaging or attempting to engage in sexual activity with any person by force, threat of force or coercion or if the victim did not or could not consent? Have you been civilly or administratively adjudicated to have engaged in the activity described above? Have you been found to have engaged in sexual harassment at work?" A review of the DHS 6 Code of Federal Regulations Part 115 form further confirms perspective employees are required to acknowledge by signature the following statement, "I understand that a knowing and willful false response may result in a negative finding regarding my fitness as a contract employee supporting ICE. Furthermore, should my answers change at any time I understand I am responsible for immediately reporting the information to my Program Manager." The Auditor reviewed the AIP application on-line and confirmed the application includes the statement "By signing this application, you certify that the information you have provided in this Application, is true and complete. You understand that if hired, inaccurate, omitted, misrepresented or incomplete statements on your Job Application or supporting attachments may result in your immediate disqualification from consideration of employment, or, if already hired, your immediate termination." The lead Auditor reviewed 21 personnel files (3 contracted STG, 3 ISHC, 4 ICE and 11 AIP) and confirmed 10 of the employee files reviewed required, and completed, five-year background checks. In addition, utilizing the PSD Background Investigation for Employees and Contractors, the Auditor submitted the names of the 21 personnel files reviewed and received documentation confirming each had completed the background process. The Auditor reviewed five volunteer files and confirmed both the DHS 6 Code forms and background checks had been completed. An interview with the HRM indicated two staff members had been promoted in the last two years. The lead Auditor reviewed their personnel files and confirmed each staff member up for promotion had completed a 6 Code of Federal Regulations Part 115 form prior to the promotion. An interview with the AFOD indicated there were no ICE staff promotions during the audit process.

Corrective Action:

No corrective action needed.

§115.18 - Upgrades to facilities and technologies.

Outcome: Meets Standard

Notes:

(a)(b): PISPC policy 4.5.13 states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility will consider the effect of the design, acquisition, expansion, or modification upon its ability to protect detainees from sexual abuse. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in the facility, the facility will consider how such technology may enhance its ability to protect detainees from sexual abuse." The lead Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center PISPC is a Service Processing Center owned and operated by U.S. Immigration and Customs Enforcement under the Department of Homeland Security. Since 2007, PISPC has not had no renovations, additions, or new construction." During the on-site audit, the Auditor observed the facility is currently undergoing construction of a kitchen and an Administrative Segregation Unit. Interviews with the AFOD and the facility Director confirmed

they were aware of the requirement to consider the effect of the design and the placement of the video monitoring system in order to protect detainees from sexual abuse.

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, Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per Policy 11062.2, "when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." PISPC policy 4.5.13 states, "The agency and facility will develop an evidence protocol referred to in paragraph above of this section, will consider how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victims' needs. The facility will establish procedures to make available, to the full extent possible, outside victim services following incidents of sexual abuse; the facility will attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency will provide these services by making available a qualified staff member from a community-based organization, or a qualified agency staff member. A qualified agency staff member or a qualified community-based staff member means an individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate will provide emotional support, crisis intervention, information, and referrals." PISPC policy 4.5.13 further states, "The Cameron County Sheriff's Office work in conjunction with Harlingen Valley Baptist Medical Center to provide medical examinations and forensic investigations related to sexual assault crimes. Any victim of assault will be transported to Harlingen Valley Baptist Medical Center. The SANE nurses at Harlingen Valley Baptist Medical Center will conduct examinations and provide referrals for on-going treatment. As requested by a victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, will be allowed for support during a forensic exam and investigatory interviews." Interviews with the FD and facility PREA Investigator indicated the facility is responsible for conducting administrative investigations and the Cameron County Sheriff's Office (CCSO) is responsible for conducting criminal investigations and the CCSO is called to the facility for every allegation of sexual abuse received. Interviews with the FD and facility PREA Investigator further indicated if there is a need for Sexual Assault Forensic Exam or Sexual Assault Nurse Examiner (SAFE/SANE) examination, the detainee would be transported to the Valley Baptist Medical Center (VBMC). The Auditor spoke with a Registered Nurse (RN) working in the emergency room at VBMC and confirmed, if needed, the hospital would provide a certified examiner to conduct a SANE/SAFE examination. In an interview with the VBMC RN it was further confirmed a victim advocate would be provided to accompany the detainee during the examination and investigative interviews to provide emotional support, crisis intervention, and counseling. The Auditor reviewed two sexual abuse allegation investigation files and confirmed there were no instances which required a SAFE/SANE exam at VBMC. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy was developed in conjunction with the AFOD. The facility does not house juveniles.

(e): PISPC policy 4.5.13 states, "The facility will request that the Cameron County Sheriff's Office follow the requirements of the Federal Register §115.21, paragraphs (a) through (d)." The lead Auditor reviewed an MOU

dated May 8, 2024, between ICE ERO, PISPC, and the Cameron County Sheriff's Department (CCSD) and confirmed the facility has requested the CCSD to follow all requirements of §115.21 (a)-(d) of the standard.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet 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)." PISPC policy 4.5.13 states, "PIDC will assure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. All reports are taken regardless of the source (detainee, staff or a third party) or the method of communication used (in writing, electronic, verbal, or any other source). The agency will ensure that the agency and facility protocols required by the paragraph above of this section, include a description of responsibilities of the agency, the facility, and any other investigating entities; and require the documentation and maintenance, for at least five (5) years, of all reports and referrals of allegations of sexual abuse. The agency will post its protocols on its Web site; the facility will also post its protocols on its Web site, if it has one, or otherwise make the protocol available to the public." PISPC policy 4.5.13 further states, "When a detainee(s) is alleged to be the perpetrator, it is the AFOD's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to the FOD, who will report it to the OPR Joint Intake Center. A Significant Event Notice (SEN) system report will also get generated. 2. When an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse and/or assault, the following will be notified immediately: the AFOD; the highest-ranking on-site ICE/ERO representative; the respective FOD; the FOD will notify: The Deputy Assistant Director, Detention Management Division, and The ICE Office of Professional Responsibility (OPR). OPR will refer the matter to the DHS Office of the Inspector General (OIG). The AFOD and/or FOD will also refer the matter to the FBI (or other appropriate law enforcement agency)." The lead Auditor reviewed PISPC policy 4.5.13 and confirmed although the policy does not include the verbiage 'require the documentation and maintenance, for at least five (5) years, of all reports and referrals of allegations of sexual abuse" it does require the documentation and maintenance of all reports and referrals of allegations of sexual abuse "in accordance with these standards;" and therefore, the lead Auditor accepts PISPC policy 4.5.13 for compliance. In an interview with the PSA Coordinator/PSA Compliance Manager it was indicated all allegations of sexual abuse are reported to the AFOD. In an interview with the AFOD it was indicated he would report the allegation to the FOD, Joint Intake Center (JIC), and ICE OPR. Interviews with the PSA Coordinator/PSA Compliance Manager and the facility PREA Investigator indicated that all allegations are immediately reported to the CCSO, and an administrative investigation would be coordinated with ICE OPR and CCSO to not interfere with a criminal investigation. The lead Auditor reviewed two investigative files and confirmed both allegations had been reported to the ICE FOD, CCSO, JIC, and the ICE OPR. The lead Auditor reviewed both the Agency website (https://www.ice.gov/prea) and the facility website (https://www.ice.gov/detain/detention-facilities/port-isabel-service-processing-center) and confirmed the Agency had posted their Administrative Investigation Protocols as

required by the standard; however, PISPC policy 4.5.13 is not posted. During the on-site audit the Auditor further confirmed through observation the protocols are not available to the public.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. The lead Auditor reviewed both the Agency website (https://www.ice.gov/prea) and the facility website (https://www.ice.gov/detain/detention-facilities/port-isabel-service-processing-center) and confirmed the Agency has posted their Administrative Investigation Protocols as required by the standard; however, PISPC policy 4.5.13 is not posted. During the on-site audit the Auditor further confirmed through observation the protocols are not available to the public. To become compliant the facility must make PISPC policy 4.5.13 available to the public.

§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." PISPC policy 4.5.13 states, "PISPC's SAAPI Program will be included in training for employees, volunteers, and contract personnel and will also be included in annual refresher training thereafter. Training will include: the facility's zero-tolerance policy for all forms of sexual abuse or assault; definitions and examples of prohibited and illegal behavior; the right of detainees and staff to be free from sexual abuse and agency prohibitions on retaliation against detainees and staff who report sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral, and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; 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; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition, and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; instruction on reporting knowledge or suspicion of sexual abuse and/or assault and making intervention referrals to the facility's program; instruction of documentation and referral procedures of all allegations or suspicion of sexual assault and/or assault, and how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees." PISPC policy 4.5.13 further states, "The facility will maintain written documentation verifying employee, volunteer and contractor training." The Auditor reviewed the 2022 ICE Sexual Abuse and Assault Prevention and Intervention (SAAPI) Awareness Training. The review confirmed all elements required by the standard are included in the curriculum. Interviews with eight random DOs indicated they are required to attend PREA training every year and they could articulate their knowledge of PREA and their responsibilities under the facility PREA prevention program. The lead Auditor reviewed 21 training files (11 AIP 3 IHSC, 3 STG and 4 ICE staff) and confirmed the training files documented that all staff had completed PREA Refresher training annually.

Corrective Action:

No corrective action needed.

§115.32 - Other training.
Outcome: Meets Standard
Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "All volunteers and other contractors who have contact with detainees will be 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 contact with detainees will be notified of the PISPC's zero-tolerance policy and informed how to report such incidents." The Auditor reviewed the ICE Prison Rape Elimination Act (PREA) Training for Contractors and Volunteers. The review confirmed the training includes both the Agency and facility zero-tolerance policy and how to report an incident of sexual abuse. The Auditor reviewed five volunteer files and confirmed each file had documentation confirming the volunteers had received the training annually. During the on-site audit, informal interviews with the Compliance Team indicated the facility had recently developed and implemented a procedure to ensure that all "other" contractors entering the facility receive PREA training. The Auditor reviewed a training memo sent via email to "all staff" and confirmed the email informs staff of the implemented updated admission procedures for "other" contractors entering the facility which required "other" contractors be required to sign an acknowledgement that they received the facility and Agency zero-tolerance policy and to report an allegation of sexual abuse. The Auditor reviewed 10 samples of the signed acknowledgement which had been completed since the new procedure went into effect.

Corrective Action:

No corrective action needed.

§115.33 - Detainee education.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(f): PISPC policy 4.5.13 states, "The AFOD will ensure that the orientation program required by the detention standard on Admission and Release, and the detainee handbook required by the detention standard on Detainee Handbook, notify and inform detainees about the PISPC's zero-tolerance policy for all forms of sexual abuse and assault. During the intake process, detainees are provided instruction on PISPC's SAAPI Program, instruction includes (at a minimum): PISPC's zero-tolerance policy for all forms of sexual abuse or assault; the name of the SAAPI Program Coordinator and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse, and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one (1) or more staff members other than an immediate point-of-contact line officer, the ICE/DRIL, the DHS/OIG and the ICE/OPR investigation processes or their consular official; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting an assault will not negatively impact the detainee's immigration proceedings; and right of a detainee who has been subjected to sexual abuse or assault to receive treatment and counseling. PISPC will provide the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. The above-mentioned detainee instruction will be documented, and such documentation will be maintained according to a prescribed schedule." Interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the facility's sexual abuse prevention and response. Interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated all detainees are provided the ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the facility Detainee Handbook Local Supplement and will watch a PREA orientation video. In addition, interviews with five random facility Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated accommodations are made to ensure effective communication is established with detainees to include, but not limited to, the use of a teletypewriter (TTY) or Telecommunication device for the deaf (TDD) phone, video remote interpreting via I-pad, a hearing aid/amplifier, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs indicated for detainees who have limited reading skills, or are limited English proficient (LEP), staff will utilize the facility language line, or a staff interpreter, who is proficient in the detainee's

preferred language, to interpret the information. Interviews with 5 random Compliance Team members, a Classification Officer, an Intake Officer, and eight random DOs further indicated if a detainee is blind, the staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure the detainee understands the PREA material provided. During the on-site audit, the lead Auditor observed the ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet were readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese. The lead Auditor reviewed the ICE National Detainee Handbook and confirmed the handbook includes information about reporting sexual abuse. In addition, the Auditor observed the facility Detainee Handbook Local Supplement, and confirmed it was readily available in 14 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. The lead Auditor reviewed the facility supplemental handbook and confirmed the handbook does not include information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services. In an interview with 5 random Compliance Team members, it was indicated in addition to the facility supplemental handbook, the facility also provides detainees PREA information in a script available in English and Spanish and for those detainees whose preferred language is not English or Spanish, the script is read to the detainees with the use of the facility language line or a staff interpreter. Prior to the on-site audit, the Auditor reviewed the script and confirmed the script advised detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional information noted in the facility supplemental handbook.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed a sample of the Detainee Education for Intake Staff Script, which did not appear to be the same as the one previously provided. A review of the on-site Detainee Education for Intake Staff Script confirmed the script informs detainees they have a right to be safe and free from sexual abuse, multiple ways for a detainee to report an allegation of sexual abuse, definitions of sexual abuse, and how to avoid sexual abuse; however, it does not include the Agency or facility zero tolerance policy, or information about, treatment or counseling that is available to a detainee victim. In interviews with a Classification Officer and an Intake Officer, it was confirmed neither staff could articulate information regarding the script to include how, or when it is utilized or if the script is read to the detainees whose preferred language is different than English or Spanish, with the use of a language line. During the on-site audit the Auditor further observed a facility video, available in English and Spanish, which was closed captioned and confirmed the video did not include any additional information noted in the facility supplemental handbook. The Auditor reviewed the files of 10 newly arrived detainees who arrived at the facility following the implementation of the updated New Arrival Orientation Program form and confirmed the use of the New Arrival Orientation Program form. Interviews with 30 detainees confirmed they had received the ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet, and the facility Detainee Handbook Local Supplement, and had seen the PREA Orientation Video: however, interviews could not confirm detainees had seen the video and received the Detainee Education for Intake Staff

Script, in a manner they could understand. To become compliant, the facility must implement a practice to ensure detainees have access to the information provided in the PREA video in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all Intake and Classification staff have received training on the implemented practice. In addition, the facility must submit 10 detainee files, to include if applicable, detainees who do not speak English or Spanish, who arrived at the facility during the CAP period to confirm detainees receive an orientation program during intake which includes information on community-based organizations utilized by the facility to provide needed counseling and crisis intervention services and information provided in the PREA video in a manner all detainees can understand.

§115.34 - Specialized training: Investigations.
Outcome: Meets Standard
Notes:

(a)(b): PISPC policy 4.5.13 states, "In addition to the general training, all facility staff responsible for conducting sexual abuse or assault investigations will receive specialized training that covers, at a minimum, 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. The facility will maintain written documentation verifying specialized training provided to investigators pursuant to this requirement." The facility PAQ indicates the facility has six investigators who have received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed the DHS PREA §115.34: Effective Cross-Agency Coordination Training curriculum and confirmed all elements are included in the training. An interview with the facility PREA Investigator indicated the six PREA Investigators, the Chief of Security, and all Shift Commanders have received the specialized training; however, only one facility PREA Investigator is responsible for conducting administrative investigations related to an allegation of sexual abuse. An interview with the facility PREA Investigator further confirmed he was knowledgeable and could articulate his responsibilities when completing a thorough and objective investigative report. The Auditor reviewed six training certificates and confirmed the certificates include a statement, "I certify that I have read and understand this Cross-agency Collaboration Training and will adhere to the procedures." The Auditor confirmed the PREA Investigation has completed the facility general PREA training as required by standard §115.31. The Auditor reviewed two sexual abuse allegation investigation files and confirmed the investigations had been completed by a qualified facility PREA Investigator.

Corrective Action:

No corrective action needed.

§115.35 - Specialized training: Medical and mental health care.
Outcome: Meets Standard
Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "The facility medical staff will be trained in procedures for examining and treating victims of sexual abuse. Such specialized training will include detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse, responding effectively to victims of sexual abuse and assault, and how and to whom to report allegations or suspicions of sexual abuse or assault. The facility will maintain written documentation verifying employee, volunteer, and contractor training." The Auditor reviewed the ICE Sexual Assault and Prevention-prison rape elimination act (PREA) training curriculum and confirmed the training includes how to detect signs and assess signs of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, how and to whom to report allegations or suspicions of sexual abuse and how to preserve physical evidence of abuse. The Auditor reviewed a training sign-in sheet and confirmed all IHSC Government Service, and STG staff have completed the training. In addition, the Auditor reviewed three IHSC staff and three STG staff training records and confirmed they had received general PREA training as required by §115.31.

Corrective Action:

No corrective action needed.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(f)(g): PISPC policy 4.5.13 states, "Detainees will be screened upon arrival at the facility for potential vulnerabilities to sexually aggressive behavior or tendencies to act out with sexually aggressive behavior and will be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new arrival will be kept separate from the general population until he or she is classified and may be housed accordingly. The initial classification process and initial housing assignment will be completed within twelve (12) hours of admission to the facility. The facility will consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: 1. whether the detainee has a mental, physical, or developmental disability; 2. the age of the detainee; 3. the physical build and appearance of the detainee; 4. whether the detainee has previously been incarcerated or detained; 5. the nature of the detainee's criminal history; 6. whether the detainee has any convictions for sex offenses against an adult or child; 7. whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; 8. whether the detainee has self-identified as having previously experienced sexual victimization; and 9. the detainee's own concerns about his or her physical safety. Detainees will not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to items (1), (7), (8), or (9) above. The initial screening will consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to PISPC, in assessing detainees for risk of being sexually abusive. The facility will implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees." PISPC policy 4.5.13 further states, "Detainees will be screened within twenty-four (24) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior. The Processing Officer will make a housing determination during the admission review (classification) of past and current criminal history. A detainee(s) considered to be a possible sexual predator will be segregated from the general population and housed in the Special Management Unit (SMU). The medical department will assess all detainees identified as a high risk with a history of any type of sexual behavior or at risk for victimization." The lead Auditor reviewed the facility Detainee Classification Risk Assessment and confirmed the assessment considers whether the detainee has a mental, physical, or developmental disability; the age of the detainee, the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; the detainee's own concerns about his or her physical safety; prior acts of sexual abuse; prior convictions for violent offenses; and a history of prior institutional violence or sexual abuse. A review of the facility Detainee Classification Risk Assessment further confirms the assessment requires staff complete the form within 12 hours; however, PISPC policy 4.5.13 requires staff screen the detainee within twenty-four (24) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior. In addition, a review of the facility Detainee Classification Risk Assessment confirms the assessment includes boxes which indicate time in and time out of the "staging" area. Interviews with an Intake Officer and a Classification Officer indicated detainees arrive through the sally port, are placed into holding cells, within a "staging" area which is used to hold both detainees being processed for admittance into PISPC, and detainees being transported to other facilities, where they are assessed to identify those likely to be sexual aggressors or sexual abuse victims. Interviews with an Intake Officer and a Classification Officer further indicated once the detainee is accepted for housing at the facility the detainee is moved to the PISPC intake area, for completion of the classification process which includes a medical assessment and initial housing

assignment. An interview with a Classification Officer indicated the "staging" area where detainees are assessed, is not considered to be part of PISPC; and therefore, staff will complete the "time in" and "time out" boxes on the assessment to confirm the time the detainee arrived and entered the "staging" area from the sally port and the time the detainee is accepted into PISPC. However, during the on-site audit, the lead Auditor, confirmed with the ERAU team lead, the "staging area" at PISPC does not include a designation as a staging facility. Therefore, the time a detainee is housed in the "staging" area must be included, when calculating the 12-hour limit to complete initial classification and housing as required by subsection (b) of the standard. Interviews with an Intake Officer and a Classification Officer indicated detainees pending acceptance into PISPC are kept separate from detainees who are being transferred or housed in general population. During the on-site tour the lead Auditor observed the intake staging area and confirmed the area has five to six stations to allow multiple detainees to be processed at one time. During the on-site audit, the Auditor further observed detainees are brought out in multiple numbers to be assessed with no privacy barrier between detainees to allow for confidentiality and to ensure sensitive information obtained from the assessment is not overheard by other staff, other detainees or inmates, which is exaggerated when intake staff must utilize a speaker phone to access the language line services for interpretation. Interviews with the Disciplinary Officer, Classification Officer, and an Intake Officer, indicated detainees are not disciplined if they refuse to answer or provide complete answers on risk assessment. The lead Auditor reviewed seven detainee files and confirmed the facility Detainee Classification Risk Assessment indicated the detainee's date and time of arrival at PISPC; however, during the on-site audit the facility submitted a Male Incoming roster and housing unit logs which confirmed the facility is not taking into consideration the time spent in the "staging" area as part of the required twelve hours from admission to complete the detainees initial classification and housing. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer confirmed they could not provide the Auditor, the names of the detainees who experienced sexual abuse or where sexual abuse perpetrators, or where they are housed in the facility. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer further confirmed staff could not articulate the housing process to prevent sexual abuse or the steps the facility takes to mitigate any such dangers. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be a sexual aggressors or sexual abuse victims until medical provided a listing of detainees based on the initial medical assessment. However, due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews or review intake, medical, and mental health records; and therefore, could not confirm the facility takes into consideration the elements required by subsection (c) of the standard to determine initial housing. During the on-site audit the lead Auditor observed and confirmed detainee files containing the initial risk assessment are filed in a secure area under lock and key.

(e): PISPC policy 4.5.13 states, "PISPC will reassess each detainee's risk of victimization or abusiveness between sixty (60) and ninety (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." PISPC policy 4.5.13 further states, "Classification is an ongoing, dynamic process. A detainee who is subjected to sexual abuse or assault will not be returned to general population until proper re-classification, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault, is completed." An interview with a Classification Officer indicated the facility reassesses each detainee's risk of victimization or abusiveness at sixty days from the date of the detainee's arrival at the facility. The interview further indicated a reassessment would be conducted based on new information learned or following an incident of sexual abuse or victimization. The Auditor reviewed seven detainee files; however, none of the detainee files indicated the detainee had been at the facility for 60 days; and therefore, the Auditor requested and reviewed 10 detainee risk reassessments and confirmed the reassessment had been completed at 60 days from the date of the initial assessment. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither detainee victim had been reassessed following the incident of abuse or victimization.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (g) of the standard. A review of the Detainee Classification Risk Assessment confirms it requires staff complete the initial risk assessment within 12 hours; however, PISPC policy 4.5.13 states, "Detainees will be screened within twenty-four (24) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior." In addition, a review of the facility Detainee Classification Risk Assessment confirms the assessment includes boxes which indicate time in and time out of the "staging" area and not the designated intake area. Interviews with an Intake Officer and a Classification Officer indicated once the detainee is accepted for housing at the facility the detainee is moved to the PISPC intake area, for completion of the classification process which includes a medical assessment and initial housing assignment. An interview with a Classification Officer indicated the "staging" area is where detainees are screened, and it's not considered to be part of PISPC. However, during the on-site audit, the lead Auditor, confirmed with the ERAU team lead, the "staging area" at PISPC does not include a designation as a staging facility. Therefore, the time a detainee is housed in the "staging" area must be included, when calculating the 12-hour limit to complete initial classification and housing as required by subsection (b) of the standard. During the on-site audit, the Auditor observed the intake area and confirmed there is no privacy barrier between detainees to allow for confidentiality and to ensure sensitive information gained from the initial assessment, is not overheard by other staff or detainees. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer confirmed they could not provide the Auditor, the names of detainees who identify as victims or sexual abuse or sexual perpetrators, or where they are housed in the facility. Interviews with 5 random facility Compliance Team members, the PSA Coordinator/Compliance Manager, a Classification Officer, and an Intake Officer further confirmed staff could not articulate the housing process to prevent sexual abuse or the steps the facility to takes to mitigate any such dangers. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or sexual abuse victims until medical provided a listing of detainees based on the initial medical assessment. However, due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews or review intake, medical, and mental health records; and therefore, could not confirm the facility takes into consideration the elements required by subsection (c) of the standard to determine when determining initial housing. The lead Auditor reviewed seven detainee files and confirmed the facility Detainee Classification Risk Assessment facility jail management documentation indicated the detainee's date and time of arrival at PISPC; however, during the on-site audit the facility submitted a Male Incoming roster and housing unit logs which further confirmed the time indicated on the risk assessment as the "time out" of the staging area; and therefore, the facility is not taking into consideration the time spent in the "staging" area as part of the required twelve hours from admission to complete the detainees initial classification and housing. To become compliant, the facility must implement a practice which includes assessing detainees within twelve (12) hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate such danger. In addition, the facility must develop and implement appropriate controls to ensure information gained during the initial risk assessment is not exploited to the detainee's detriment by staff, other detainees, or inmates. Once implemented the facility must submit documentation which confirms all applicable staff, to include Intake, Classification, and security supervisors, have been trained on the implemented practice. In addition, the facility must submit 10 detainee files who arrive during the CAP period to confirm the required practices have been implemented.

The facility is not in compliance with subsection (e) of the standard. An interview with a Classification Officer indicated a risk reassessment would be conducted following an incident of sexual abuse or victimization. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither detainee victim had been reassessed following the incident of abuse or victimization. To become compliant, the facility must submit documentation to confirm all applicable staff, to include facility investigators, have received training on the standard's requirement to reassess a detainee's risk for sexual victimization following an incident of sexual abuse or victimization. In addition, if applicable, the facility must submit all closed sexual abuse investigation files

which occur during the corrective action plan (CAP) period to confirm a reassessment had been completed after an incident of sexual abuse or victimization.

§115.42 - Use of assessment information.
Outcome: Does Not Meet Standard
Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "The facility will use the information from the risk assessment to inform assignment of detainees to housing, recreation and other activities, and voluntary work. The agency will make individualized determinations about how to ensure the safety of each detainee." PISPC policy 4.5.13 further states, "When making assessment and housing decisions for a transgender or intersex detainee, the facility will consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility will consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs will always be taken into consideration as well. The facility's placement of a transgender or intersex detainee will be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee will be reassessed at least twice each year to review any threats to safety experienced by the detainee. When operationally feasible, transgender and intersex detainees will be given the opportunity to shower separately from other detainees." In addition, PISPC policy 4.5.13 states, "Detainees will be screened within twenty-four hours of arrival to the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior. The Processing Officer will make housing determinations during the admission review (classification) of past and current criminal history. A detainee(s) considered to be a possible sexual predator will be segregated from the general population and housed in the Special Management Unit (SMU)." Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team confirmed they could not provide the Auditor with the names of the detainees who identified as to be sexual abuse aggressors or sexual abuse victims during intake or where they are housed in the facility. Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team further confirmed they could not articulate how the facility utilizes the information obtained from the risk assessment, in making individualized determination that can ensure the detainee's safety, for the assignment of housing, recreation, voluntary work or other activities. Interviews with a Classification Officer and an Intake Officer indicated medical and mental health are consulted on the placement of all detainees including transgender or intersex detainees. In an interview with a Classification Officer it was indicated, a transgender or intersex detainee will be reassessed twice a year to ensure his/her safety. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or sexual abuse victims. During the exit briefing, medical staff provided the Auditor a medical roster of those detainees that had been identified as an aggressor or as a sexual abuse victim, based on the initial medical assessment conducted; however, due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews or review detainee, medical, and mental health files to determine if the initial risk assessment is considered in determining housing, recreation, programming and other activities. An interview with the AHSA indicated housing for a transgender or intersex detainee is determined based on the detainee's own self-identification of gender and not by physical anatomy; however, the safety and security of the facility is also considered. An interview with the AHSA further indicated a transgender/intersex detainee is initially housed in the medical unit until the Transgender Care Committee (TCC) can meet and discuss the detainee's placement, which will occur within 72 hours. An interview with a transgender detainee indicated she is housed in the medical unit and has been housed in the medical unit since arriving at the facility approximately 10 days earlier; however, an interview with the AHSA confirmed the transgender detainee remained in the medical unit due her classification level and not due to being vulnerable to sexual abuse. The lead Auditor reviewed the transgender's file and confirmed the transgender detainee was seen by the TCC within 72 hours and her placement in medical was due to a classification issue and not due to her being vulnerable to sexual abuse. An interview with eight

random DOs and a transgender detainee indicated all transgender/intersex detainees are given an opportunity to shower separately from other detainees in the medical area.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. During the on-site audit, although requested, the facility could not provide the Auditor with rosters of detainees who had been identified as likely to be a sexual aggressor or sexual abuse victims. Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team confirmed they could not provide the Auditor with the names of the detainees who identified as to be sexual abuse aggressors or sexual abuse victims during intake or where they are housed in the facility. Interviews with the PSA Compliance Manager, a Classification Officer and Intake Officer, and informal discussions with the Compliance Team further confirmed they could not articulate how the facility utilizes the information obtained from the risk assessment, in making individualized determination that can ensure the detainee's safety, for the assignment of housing, recreation, voluntary work or other activities. Interviews with a Classification Officer and an Intake Officer indicated medical and mental health are consulted on the placement of all detainees including transgender or intersex detainees. During the exit briefing, medical staff provided the Auditor a medical roster of those detainees that had been identified as an aggressor or as a sexual abuse victim, based on the initial medical assessment conducted, during the intake process; however, due to the timing of the receipt of the roster, the Auditor was unable to conduct follow-up interviews to determine if a process has been established to mitigate any dangers. To become compliant, the facility shall develop and implement a process to utilize the information from the risk assessment to inform assignment of detainees to housing, recreation, and voluntary work or other activities. Once implemented, the facility shall submit documentation to confirm all applicable staff, to include intake, medical and classification staff, have been trained on the implemented process. In addition, the facility shall provide the Auditor 10 detainee files to confirm information obtained from the risk assessment was utilized to determine the detainees housing, recreation, and voluntary work or other activities.

<u>§115.43 - Protective custody.</u>
Outcome: Does Not Meet Standard
Notes:

(a)(b)(c)(d)(e): PISPC policy 4.5.13 states, "The facility will develop and follow written procedures consistent with the standards in Protective Custody for the facility governing the management of its administrative segregation unit. The procedures will be developed in consultation with the ICE Enforcement and Removal Operations Field Office Director having jurisdiction for the facility and must document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at PISPC, the facility will consult with the FOD for additional assistance. Such detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, regular review of detainee must be provided. The Contract Security Shift Commander will conduct a review within seventy-two (72) hours of a detainee's initial placement in administrative segregation to determine if administrative segregation is warranted. The status of all detainees will be reviewed by a Contract Security Shift Commander after the detainee has spent seven (7) days in administrative segregation, and every week thereafter, for the first thirty (30) days and every ten (10) days thereafter, at a minimum. Such an assignment will not ordinarily exceed a period of thirty (30) days." PISPC policy 4.5.13 further states, "Care will be taken to place the detainee in a supportive environment that represents the least restrictive housing option possible (e.g. protective custody), and to the extent possible, permit the victim the same level of privileges he or she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical and mental health needs of the alleged victim. However, victims will not be held for longer than five (5) days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. PISPC will notify the FOD no later than seventy-two (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 lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy does not include the requirement to document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. The Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center has no record of a detainee in protective custody/administrative segregation that demonstrates a review by supervisor staff at the following intervals: within 72 hours of placement, every 7 days for the first month and, if necessary, every 10 days thereafter that has occurred during the audit period at the Port Isabel Detention Center." An interview with the FD and Auditor observations, confirmed the facility does not have an administrative segregation/protective custody unit and if a detainee is at risk for sexual victimization, the detainee would be moved to another unit, where he would be able to participate in programs, visitation, counsel, and all other services available to the general population. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy was developed in consultation with the AFOD.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy does not include the requirement to document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. To become compliant the facility must submit documentation to confirm PISPC policy 4.5.13 was updated in consultation with the FOD to include the requirement to document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Once updated the facility must submit documentation to confirm all security staff were trained on updated PISPC policy 4.5.13.

§115.51 - Detainee reporting.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "The PISPC Detainee Handbook provides instructions for detainees to immediately report an incident of sexual assault/abuse. Any report, whether verbal, in written, anonymously and from third parties may be submitted to any staff member. Reports of sexual abuse/assault or attempted sexual abuse/assault allegations will be immediately forwarded to an ICE Supervisor on duty or designee. Detainees will have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse or assault, and/or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting." The Detainee Handbook Local Supplement states, "Detainees have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting." Interviews with 5 random Compliance Team members and eight random DOs indicated detainees are provided multiple ways to report an allegation of sexual abuse, retaliation, and/or any staff neglect of their responsibilities which may have contributed to an incident of sexual abuse. During the on-site audit, the lead Auditor observed PREA information in all common areas of the facility and near the detainee telephones in English and Spanish which included the DHS-prescribed sexual assault notice, the Detention and Reporting Information Line (DRIL) poster, DHS Office of Inspector General (OIG) poster, the Rape Abuse, and Incest National Network (RAINN) poster, the facility PREA Hotline number, Sexual Assault Victim Service Provider flyer, and information for contacting consular officials. However, during the on-site audit, the lead Auditor reviewed the written information provided to all detainees during intake/orientation and confirmed written information provided did not include the information available in the Sexual Assault Victim Service Provider flyer in a manner all detainees can understand. In addition, during the on-site audit, the lead Auditor tested the telephone numbers provided for the DRIL and DHS OIG and confirmed they were in good working order; however, the Auditor utilizing a detainee pin number, tested the number posted for the PISPC PREA Hotline by leaving a message with instructions to immediately inform the PSA Compliance Manager or the Audit Team once it had been received; however, neither PSA Compliance Manager or the Audit Team received a response; and therefore, the Auditors could not confirm

the PISPC PREA Hotline provided by the facility to report an allegation of sexual abuse is in good working order. Interviews with 30 random detainees indicated they were aware there were several ways they could report an allegation of sexual abuse at PISPC, including ways to report anonymously, if needed.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. PISPC policy 4.5.13 states, "The PISPC Detainee Handbook provides instructions for detainees to immediately report an incident of sexual assault/abuse. Any report, whether verbal, in written, anonymously and from third parties may be submitted to any staff member. Reports of sexual abuse/assault or attempted sexual abuse/assault allegations will be immediately forwarded to an ICE Supervisor on duty or designee." However, during the on-site audit the lead Auditor tested the facility PREA hotline number by leaving a message with instructions to immediately inform the PSA Compliance Manager or the Audit Team once the message was received and did not get a response. To become compliant, the facility must submit documentation to confirm the facility PREA Hotline, provided to the detainees, is in good working order.

§115.52 - Grievances.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): PISPC policy 4.5.13 states, "Formal grievances related to sexual abuse and assault may be filed at any time during, after, or in lieu of lodging an informal grievance or complaint and with no time limit imposed on when a grievance may be submitted. A grievance that involves an immediate threat to a detainee's health, safety, or welfare related to sexual abuse or assault will be responded to as an emergency grievance. Immediate notification must be made to an ICE Supervisor on duty who will in turn notify the AFOD as needed. Emergency medical grievances will be immediately brought to the attention of proper medical personnel for further assessment. These notifications will be made even if it is later determined that the issue did not present an emergency. Emergency grievances not resolved at the shift level will be forwarded up the chain of command in a timely matter until the matter is resolved. Decisions on grievances will be issued within five (5) days of receipt and appeals will be responded to within thirty (30) days. Detainees may obtain assistance from another detainee, the Housing Unit Officer or other facility staff, family members, or legal representatives. Staff will take reasonable steps to expedite requests for assistance from these other parties. All grievances related to sexual abuse and the facility's decision on any such grievance must be forwarded to the FOD." The Detainee Handbook Local Supplement states, "Formal grievances related to sexual abuse and assault may be filed at any time during, after, or in lieu of lodging an informal grievance or complaint and with no time limit imposed on when a grievance may be submitted. Detainees may obtain assistance from another detainee, the housing unit officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties." An interview with the facility GO indicated detainees could file a grievance alleging sexual abuse at any time and are not required to follow an informal grievance process prior to filing a formal grievance through the paper system or the detainee tablets. An interview with the facility GO further indicated paper grievances are submitted through a locked grievance box in each housing unit and are picked up daily by ICE staff. In addition, an interview with the GO indicated if a detainee expressed the need for assistance, because they are illiterate, LEP, or have other disabilities, staff or family can assist them. An interview with the facility GO further indicated all grievances alleging sexual abuse are considered emergency grievances; and therefore, they are time sensitive and a threat to detainee health, safety and welfare of the detainee and would require the detainee to immediately be separated, medical and mental health would be contacted, and the grievance will be immediately referred to the facility PREA investigator who will respond to the grievance within five days. In addition, an interview with the facility GO indicated once the investigation is completed and there is a resolution, the grievance will be closed, a copy of the grievance, and the results are sent to the ICE FOD, and the detainee is able to appeal any decision made. In addition, the facility GO indicated she has not received a grievance alleging sexual abuse, since she started her employment at the facility; however, she has closed one out. During the on-site audit, the Auditor placed a test grievance into a locked grievance box with

instructions to notify the PREA Auditors or the team lead, immediately upon receipt of the grievance. Within a few hours, the Auditor was informed the test grievance had been received. The Auditor reviewed two sexual abuse allegation investigation files and confirmed one allegation had been received through the grievance process and the grievance and the results had been forwarded to the AFOD.

Corrective Action:

No corrective action needed.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): PISPC policy 4.5.13 states, "Detainee will be informed prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. If available and offered by a community facility, prophylactic treatment, emergency contraception and follow-up examinations for sexually transmitted diseases will be offered to all victims, as appropriate." PISPC policy 4.5.13 further states, "Reports to Outside Agencies that have a Memoranda of Understanding with the Facility

- Friendship of Women, Inc. 95 East Price Rd. Brownville, Texas 78521, Hotline (956) 544-7412
- Family Crisis Center, Inc., 616 West Taylor Ave., Harlingen, TX 78550, Hotline (956) 423-9304
- Women Together/Mujeres Unidas, 511 North Cynthia St., McAllen, TX 78501, Hotline (800) 580-4879"

During the on-site audit the lead Auditor reviewed the Detainee Handbook Local Supplement and confirmed the handbook states, "Outside agencies may forward any reports of abuse to the facility and authorities in accordance with mandatory reporting laws. Such communications will be monitored." A review of the Detainee Handbook Local Supplement further confirmed the handbook includes, "Emotional support is available from the facility's mental health and medical staff, and from the chaplains." Interviews with 5 random Compliance Team members indicated the facility maintains a Memorandum of Understanding (MOU) with Women Together/Mujeres Unidas. The Auditor reviewed the MOU, dated March 18, 2024, with no expiration date, between Women Together/Mujeres Unidas and PISPC and confirmed the MOU states, "Women Together/Mujeres Unidas agrees that ERO Harlingen at PIDC may post their contact information throughout the facility as part of the PIDC "Safe Hotline, Sexual Assault Victim Service Providers" flyer. Contact phone numbers and email addresses are displayed on the flyer." A review of the MOU further confirms Women Together/Mujeres Unidas will provide counseling, at no cost to the detainee, if requested by the detainee;" however, the MOU does not include the standard's requirements to provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, and legal advocacy as required by subsection (a) of the standard. During the on-site audit, the Auditor observed the Sexual Assault Victim Service Provider flyer located within the Wall Reference Organizer posted in each housing unit. The Auditor reviewed the flyer and confirmed the flyer was in English and Spanish, provided phone numbers for Friendship of Women, the Family Crisis Center, Inc., and Women Together/Mujeres Unidas, and did not provide the detainee with mailing addresses. Upon notification, the facility updated and reposted the flyers; however, the posters were only available in English and Spanish; and therefore, the information is not made available in a manner all detainees can understand. During the on-site audit the Auditor further observed a flyer with instructions on how to place an anonymous calling, in English and Spanish, posted in the housing units and confirmed the poster include how to place an anonymous call to the DRIL, DHS OIG, Joint Intake Center (JIC), National Rape Hotline, the State Sexual Abuse Hotline, and an Emergency Hotline. However, during the on-site audit the Auditor confirmed information included on the flyers for the National Rape Hotline, the State Sexual Abuse Hotline, and an Emergency Hotline is provided to detainees is in English and Spanish only; and therefore, the information is not being provided to all detainees in a manner they can understand. The Auditor tested all numbers provided and confirmed the State Sexual Abuse Hotline and a number assigned to "Outside PREA", indicated these numbers did not exist. A test of the posted numbers further confirmed there was no anonymous number posted for the local Sexual Assault Service Provider. Upon notification the Compliance Team immediately worked with Talton to repair the issues and once the issues had been repaired, the Compliance

Team replaced all the instruction flyers within the units, Talton sent out a broadcast to all detainee tablets to inform the detainee of the changes, and the lead Auditor tested all numbers, utilizing the detainee phones, and confirmed they were in good working order. During the on-site audit the lead Auditor contacted, via telephone, Women Together/Mujeres Unidas and spoke with a victim advocate. In an interview with the advocate, it was confirmed the advocate was not aware of the MOU and would not provide services to detainees at PISPC; however, if a detainee were to call the hotline, or needed a SANE examination, they would transfer them to another agency closer to the facility to provide the needed services. The lead Auditor unsuccessfully attempted to call the Executive Director of Women Together/Mujeres Unidas; and therefore, could not confirm the organization would provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, or legal advocacy as required by subsection (a) of the standard. Interviews with 30 random detainees confirmed they were not aware of the services provided for emotional support to most appropriately address their needs should they be a victim of sexual abuse. The facility did not provide MOUs for either Friendship of Women or the Family Crisis Center, Inc, as noted in PISPC policy 4.5.13.

Corrective Action:

The facility is not in compliance with subsections (a) and (c) of the standard. The Auditor reviewed an MOU, dated March 18, 2024, with no expiration date, between Women Together/Mujeres Unidas and PISPC and confirmed the MOU states, "Women Together/Mujeres Unidas if requested the organization will provide counseling services at no cost to the detainee; however, the MOU does not include the standard's requirements to provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, and legal advocacy as required by subsection (a) of the standard." During the on-site audit the lead Auditor contacted, via telephone, Women Together/Mujeres Unidas and spoke with a victim advocate. In an interview with the advocate, it was confirmed the advocate was not aware of the MOU and would not provide services to detainees at PISPC; however, if a detainee were to call the hotline, or needed a SANE examination, they would transfer them to another agency closer to the facility to provide the needed services. The lead Auditor unsuccessfully attempted to call the Executive Director of Women Together/Mujeres Unidas; and therefore, could not confirm the organization would provide crisis intervention, investigation and prosecution of sexual abuse perpetrators, or legal advocacy as required by subsection (a) of the standard. During the on-site audit, the lead Auditor reviewed the written information provided to all detainees during intake/orientation and confirmed written information provided did not include the information available in the Sexual Assault Victim Service Provider flyer in a manner all detainees can understand. To become compliant, the facility must maintain or attempt to enter into a MOU with an outside organization to provide detainee victims of sexual abuse with crisis intervention, investigation and prosecution of sexual abuse perpetrators, and legal advocacy as required by subsection (a) of the standard. In addition, the facility must implement a practice to ensure detainees are provided the information available in the Sexual Assault Victim Service Provider flyer prior to in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all Intake and Classification staff have received training on the standard's requirement to make available to detainees information about local organizations that can assist detainees who have been victims of sexual abuse in a manner all detainees can understand.

§115.54 - Third-party reporting.

Outcome: Does Not Meet Standard

Notes:

PISPC policy 4.5.13 states, "PISPC will establish a method to receive third-party reports of sexual abuse in its facility and will make available to the public information on how to report sexual abuse on behalf of a detainee. PISPC provides detainees and their attorneys, family, friends, and associates multiple ways to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. Third parties not connected to a detainee can also report these allegations. Reports are confidential and may be made anonymously, both verbally and in writing." A review of the facility website (https://www.ice.gov/detain/detention-facilities/port-isabel-service-processing-center) confirmed the facility

provides the public with multiple ways to report sexual abuse, retaliation for reporting sexual abuse, staff neglect, or violations of responsibilities that may have contributed to such incidents, on behalf of a detainee. A review of the facility website further confirms the website provides addresses and telephone number for the DHS OIG, the DRIL, and ICE OPR. A review of the Agency website (www.ice.gov/prea) confirmed it provides the public with information (telephone number & address) regarding third-party reporting of sexual abuse on behalf of the detainee to include the DHS OIG, the DRIL, and ICE OPR. The lead Auditor tested the phone number for the DHS OIG and confirmed it is in good working order. In addition. the lead Auditor tested the telephone number for the DRIL and confirmed it was in good working order. Also, the lead Auditor completed the on-line reporting form, and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the form is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the form provided by the Agency to report an allegation of sexual abuse was in good working order. The Auditor tested the telephone number for ICE OPR and confirmed it was in good working order. Also, the Auditor sent an email to the address provided and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the email address is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the email address provided by the Agency to report an allegation of sexual abuse was in good working order.

Corrective Action:

The Agency is not compliant with standard 115.54. The lead Auditor tested the telephone number for the DRIL and confirmed it was in good working order. Also, the lead Auditor completed the on-line reporting form, and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the form is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the form provided by the Agency to report an allegation of sexual abuse was in good working order. The Auditor tested the telephone number for ICE OPR and confirmed it was in good working order. Also, the Auditor sent an email to the address provided and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the email address is in good working order; however, the Auditor did not receive a response; and therefore, could not confirm the email address provided by the Agency to report an allegation of sexual abuse was in good working order. To become compliant the Agency must submit documentation which confirms all resources provided by the Agency to report an allegation of sexual abuse are in good working order.

§115.61 - Staff reporting duties.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." 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." PISPC policy 4.5.13 states, "Staff must report any knowledge, suspicion, or information regarding an incident of 1) sexual abuse that occurred in the facility; 2) retaliation against detainees or staff that reports, complains about, or participated in an investigation about sexual abuse or assault; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff must also be able to report the above outside of the chain of command and accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." Interviews with eight random DOs confirmed they were very knowledgeable and could articulate their responsibilities to immediately 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. The lead Auditor

reviewed PISPC policy 4.5.13 and confirmed the policy does not include an avenue in which staff can make a report of sexual abuse outside the chain of command. Interviews with eight random DOs further confirmed they were aware they could only share information regarding an allegation of sexual abuse to those who are on a need-to-know basis. In addition, interviews with eight random DOs confirmed the officers struggled with articulating avenues available to them for reporting an allegation of sexual abuse outside the chain of command. Several responded they could call CCSO, while others said they would more than likely call the OIG. An interview with the AFOD indicated he was knowledgeable regarding his reporting responsibilities when the allegation includes a vulnerable adult. The Auditor reviewed two investigative files and confirmed the allegations did not involve a vulnerable adult. The Auditor reviewed PISPC policy 4.5.13 and confirmed the policy has been submitted and approved by the Agency. The facility does not house juveniles.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy does not include an avenue in which staff can make a report of sexual abuse outside the chain of command. Interviews with eight random DOs confirmed the officers struggled with articulating an avenue available to them to report an allegation of sexual abuse outside the chain of command. To become compliant, the facility must revise PISPC policy 4.5.13, to include a method by which staff can report an allegation of sexual abuse outside of their chain of command. Once revised, the facility must submit documentation to confirm all staff have received training on the revised policy.

§115.62 - Protection duties.

Outcome: Meets Standard

Notes:

PISPC policy 4.5.13 states, "All staff and detainees are responsible for being alert to signs of potential situations in which sexual assaults might occur, and for making reports and intervention referrals as appropriate. If a staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she will take immediate action to protect the detainee." In an interview with the FD, it was indicated if a staff member is alleged to have perpetrated sexual abuse the staff member would be assigned to a post that does not have detainee contact. Interviews with the FD and eight random DOs confirmed if they become aware a detainee is at substantial risk of sexual abuse their first response would be to ensure the safety of the detainee by removing the detainee from the immediate threat. The Auditor reviewed two sexual abuse allegation investigation files and confirmed each investigation included an incident report confirming staff took immediate action to protect the detainee by separating the detainee victim from the alleged abuser.

Corrective Action:

No corrective action needed.

§115.63 - Reporting to other confinement facilities.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): PISPC policy 4.5.13 states, "Upon receiving an allegation that a detainee was sexually abused or assaulted while confined at another facility, the AFOD will notify the FOD and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than seventy-two (72) hours after receiving the allegation. The AFOD will notify the detainee in advance of such reporting. PISPC will document that it has provided such notification. The facility will ensure the allegation is referred for investigation and reported to the FOD. In the event another facility notifies that a detainee reported an incident of sexual abuse or assault at PISPC, the aforementioned will be adhered to." The Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center has no record of notification of a sexual abuse that occurred at another confinement facility after transferring during the audit period. Upon receiving an allegation that a detainee was sexually abused or assaulted which confined at another facility, the Assistant Field Office Director will notify the

Field Office Director and the appropriate administrator of the facility where the alleged abuse occurred in writing as soon as possible, but no later than seventy-two (72) hours after receiving the allegation." An interview with the FD indicated he would notify the appropriate agency officials where the alleged sexual abuse occurred as soon as possible; however, no later than 72 hours after receiving the allegation. An interview with the FD further indicated the notification would be made by telephone and would be followed up with an email to document the notification. In addition, the facility Director indicated, if the facility received notice from another facility a detainee has alleged an incident of sexual abuse while housed at PISPC he would notify the AFOD and ensure that the allegation is immediately assigned for investigation. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither allegation occurred at another facility, or another facility reported the allegation occurred at PISPC.

Corrective Action:

No corrective action needed.

§115.64 - Responder duties.

Outcome: Meets Standard

Notes:

(a)(b): PISPC policy 4.5.13 states, "If staff discovers an assault in progress, the suspected victim will be removed from the immediate area for care and for interviewing by appropriate staff. The suspected victim will be segregated for interviewing by ICE OPR. The victim and the alleged assailant will be separated immediately. The victim will be referred for a medical examination and/or clinical assessment for potential negative symptoms. If a suspected victim is fearful of being labeled an informant, he or she will be advised that the identity of the assailant(s) is not needed in order for him or her to receive assistance. The first security staff member who first identifies or suspects that a detainee has been abused or an assault may have occurred should refer the matter to their immediate supervisor, investigative supervisor or designee. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder will: • preserve and protect to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any 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; • 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; and • If the first staff responder is not a security staff member, the responder will request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." Interviews with eight DOs indicated if detainee reported an allegation of sexual abuse to them, they would separate the detainee, call for backup, secure the scene and request the detainee victim and ensure the abuser does not take any action that could destroy physical evidence. Interviews with two non-custody first responders indicated they would immediately call for officers, instruct the detainees to separate, request the victim not to take any action which could destroy physical evidence, would ensure the perpetrator does not take action which could destroy physical evidence, and would immediately notify their supervisor of the incident. The Auditor reviewed two sexual abuse investigation files and confirmed each investigation included an incident report which confirmed the victim, and the abuser, were immediately separated and taken to medical for care and observation.

Corrective Action:

No corrective action needed.

§115.65 - Coordinated response.

Outcome: Meets Standard

Notes:

(a)(b): PISPC policy 4.5.13 states, "PISPC uses a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a Sexual Assault Response Team (SART), which in accordance with community practices,

includes a medical practitioner, a mental health practitioner, a security staff member and an investigator from the assigned investigative entity (ICE OPR), as well as representatives from outside entities that provide relevant services and expertise." PISPC policy 4.5.13 further states, "To ensure that every person in the facility who has the responsibility for responding to an incident of sexual abuse, including first responders, medical and mental health practitioners, investigators, and facility leadership, understands precisely what their roles are and how their roles interact with others' so that the facility achieves an effective, coordinated response to every incident of sexual abuse. Staff first responders: Staff first responders are responsible for separating victims from abusers, preserving any crime scene, and ensuring that physical evidence from the alleged victim or abuser is protected until appropriate steps can be taken to collect any evidence. Medical practitioners: Medical staff (and/or mental health staff) will ensure that all victims are offered access to any necessary emergency medical treatment and forensic medical examinations, as appropriate. Mental health practitioners: Mental health (or medical) staff will attempt to make a victim advocate from a rape crisis center available to the victim or provide access to a qualified staff member from a community-based organization, or to a qualified staff member. Investigators: Investigators with specialized training will be notified of the allegation or incident and perform the appropriate investigatory tasks. Facility leadership: Facility leadership must ensure that the following Standards are implemented, as appropriate: • Post-allegation protective custody. • Detainee access to outside community resources and services. • Reporting to other confinement facilities. • Agency protection against retaliation. • Reporting to detainees. • Disciplinary sanctions for staff. • Corrective action for contractors/volunteers. • Disciplinary sanctions for detainees. • Ongoing medical and mental health care for sexual abuse victims and abusers. • Sexual abuse incident reviews." The Auditor reviewed the facility coordinated response plan and confirmed the plan takes a multidisciplinary team approach to responding to sexual abuse. The plan coordinates the actions taken by facility responders to include first responders, medical and mental health staff, investigators, and the facility leadership in response to an incident of sexual abuse. Interviews with eight random DOs indicated if a detainee reported an allegation of sexual abuse to them, they would separate the detainee, call for backup, secure the scene, request the detainee victim, and ensure the abuser does not take any action that could destroy physical evidence. The Auditor reviewed two investigative files and confirmed the facility utilized a coordinated, multidisciplinary response, in responding to each allegation.

(c)(d): PISPC policy 4.5.13 states, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility will, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services. If a victim is transferred from a DHS immigration detention facility to a facility not covered by the paragraph list above, the sending facility will, 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. Where an alleged victim of sexual abuse or assault that occurred elsewhere in ICE custody is subsequently transferred to the detention facility, the facility will comply with all response and intervention requirements outlined by this policy, as appropriate based on the nature and status of the case." The lead Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center has no record of notification given to a receiving facility (by the DHS PREA Standards) that a victim of sexual abuse was transferred and their potential need for medical or social services during the audit period. If a victim is transferred between detention facilities, the Assistant Field Office Director (AFOD) will, as permitted by law, inform in writing of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility, request will be documented. If the receiving facility is unknown to PISPC, the AFOD will notify the Field Office Director, so that he or she can notify the receiving facility." Interviews with the FD and AFOD confirmed they were aware of the requirements of PISPC 4.5.13 and subsections (c) and (d) of the standard.

Corrective Action:

No corrective action needed.

§115.66 - Protection of detainees from contact with alleged abusers.
Outcome: Meets Standard
Notes:

PISPC policy 4.5.13 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse or assault will be removed from all duties requiring detainee contact pending the outcome of an investigation." Interviews with the FD and HRM indicated staff would be removed from having any contact with detainees pending the outcome of the investigation. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither investigation involved a staff member.

Corrective Action:

No corrective action needed.

§115.67 - Agency protection against retaliation.
Outcome: Meets Standard
Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "PISPC will employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. For at least ninety (90) days following a report of sexual abuse or assault, PISPC will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and will act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments by staff. The facility will continue such monitoring beyond ninety (90) days if the initial monitoring indicates a continuing need." An interview with the facility PREA Investigator/Retaliation Monitor, indicated he is responsible for retaliation monitoring of a detainee victims and detainees or staff who witnesses or cooperate with an investigation into an incident of sexual abuse. An interview with the facility PREA Investigator/Retaliation Monitor further indicated when a detainee reports an allegation of sexual abuse, the detainee victim would be separated from the abuser, and he will immediately meet with the detainee victim. If the detainee victim expresses a fear of retaliation for reporting the allegation or for cooperating with the investigation, he will begin a separate investigation and will ensure the detainee is offered emotional support services. In addition, an interview with the facility PREA Investigator/Retaliation Monitor indicated retaliation monitoring would include reviewing the detainee victim's disciplinary reports and any housing or programming changes which may have occurred. An interview with the facility PREA Investigator/Retaliation Monitor indicated if a staff member expressed a fear of retaliation for reporting an allegation of sexual abuse or for cooperating with the investigation, they would be offered emotional support through the employee assistance program and with the help of the HRM he would determine if a staff member had been reassigned to another post or received a reprimand in connection with the allegation. The lead Auditor reviewed the Retaliation Monitoring Sheet which is utilized to document retaliation monitoring and confirmed the sheet documents monitoring at 30, 60 and 90 days and will be continue for longer if needed. The Auditor reviewed two sexual abuse allegation investigation files and confirmed the detainee victims had been monitored for retaliation up to their release from the facility.

Recommendation (c): The Auditor recommends the Retaliation Monitor documents the first meeting with the detainee on the Retaliation Monitoring Sheet, and not at 30 days, to be consistent with facility practice.

Corrective Action:

No corrective action needed.

§115.68 - Post-allegation protective custody.
Outcome: Meets Standard
Notes:

(a)(b)(c)(d): PISPC policy 4.5.13 states, "The facility will take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible (e.g., protective custody), subject to the requirements of § 115.43 of the Federal Register." PISPC policy 4.5.13 further states, "A detainee victim who is in protective custody after having been subjected to sexual abuse will not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault." The lead Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center has not placed a detainee during the audit period into segregated housing for sexual abuse or assault." An interview with the FD, and the lead Auditor's observations, confirmed the facility does not have an administrative segregation/protective custody unit; however, the facility is currently building an administrative segregation/protective custody unit. An interview with the FD indicated a detainee victim of sexual abuse would be moved to another unit; however, if the detainee requested protective custody, the AFOD would be notified, and arrangements would be made to transfer the detainee to another facility. An interview with a Classification Officer indicated a detainee victim would not be placed back into general population until the completion of a reassessment taking into account the increased vulnerability as a result of the recent sexual abuse. The Auditor reviewed two sexual abuse allegation investigation files and confirmed the detainee victims were not placed into a segregation or protective custody unit.

Corrective Action:

No corrective action needed.

§115.71 - Criminal and administrative investigations.
Outcome: Meets Standard
Notes:

(a)(b)(e)(f): PISPC policy 4.5.13 states, "If a detainee alleges sexual assault, a sensitive and coordinated response is necessary. All investigations into alleged sexual assault must be prompt, thorough, objective, fair and conducted by qualified investigators. The program coordinator will be responsible for reviewing the results of every investigation of sexual abuse." PISPC policy 4.5.13 further states, "Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation will be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility will review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations will be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity." In addition, PISPC policy 4.5.13 states, "The departure of the alleged abuser or victim from the employment or control of the facility will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse and assault, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation." An interview with the facility PREA investigator indicated all allegations of sexual abuse are immediately reported to the CCSO and the PSA Coordinator/Compliance Manager. An interview with the facility PREA investigator further indicated the PSA Coordinator/Compliance Manager will remain in contact with the CCSO to ensure she is informed of the progress of the criminal investigation and will inform the facility PREA Investigator when he can begin an administrative investigation. In addition, an interview with the facility PREA investigator indicated an investigation would be completed even if the detainee or the perpetrator were no longer housed or employed at the facility. The Auditor reviewed two sexual abuse allegation investigation files and confirmed all elements required by the subsections (a), (b), (e) and (f) of the standard were followed including notification to the CCSO. Interviews with the facility PREA Investigator indicated there are six trained PREA Investigators who conduct sexual abuse allegation administrative investigations at PISPC. The lead Auditor reviewed two sexual abuse allegation investigation files and confirmed each investigation had been completed promptly, thoroughly, and objectively by a qualified investigator, who had completed the specialized

training as per §115.34 and the general PREA training as per §115.31.

(c): PISPC policy 4.5.13 states, "Investigations regarding allegations of sexual abuse will be initiated by any staff member. Upon identifying that a sexual assault or threat has occurred, the alleged victim will be immediately relocated to a safe and secure location. It is imperative that the alleged victim be separated from the alleged perpetrator. Staff members will attempt to identify the alleged perpetrator(s) and segregate pending a full investigation. Any allegation of sexual abuse will be immediately reported through the PISPC Chain of Command. Staff can report outside the chain of command verbally, in writing, anonymously, and promptly document any verbal reports. All affected areas will be on lockdown pending interviews of all persons at or near the area of the alleged act. The Administrative Investigator will interview and obtain written statements from the alleged victim, alleged perpetrator, and witnesses. The preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data will be collected. Review prior complaints and reports of sexual abuse or assault involving the suspected perpetrator. Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph. The Administrative Investigator will determine whether actions or failures to act at the facility contributed to the abuse. Documentation of each investigation by written report will include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five (5) years. The alleged victim will be immediately screened and evaluated by the medical department. The victim will be informed of their right to report the alleged incident to any local law enforcement agency for possible criminal prosecution." Interviews with the facility PREA Investigator, confirmed an investigation will be completed regardless of a departure of the alleged abuser or victim from the employment or control of the facility. The Auditor reviewed two investigative files and confirmed each investigation was documented by a written report which included a description of the physical and testimonial evidence, the reasoning behind credibility assessments, a review of prior complaints and reports of sexual abuse involving the abuser, efforts to determine whether staff actions or failures to act contributed to the abuse, and the investigative facts and findings.

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." PISPC policy 4.5.13 states, "The facility uses no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated." An interview with the facility PREA Investigator indicated the facility does not impose a standard higher than a preponderance of evidence to substantiate an allegation of sexual abuse. The lead Auditor reviewed two sexual abuse allegation investigation files and confirmed the outcomes of the investigations were not based on a standard higher than a preponderance of evidence.

Corrective Action:

No corrective action needed.

§115.73 - Reporting to detainees.

Outcome: Meets Standard

Notes:

PISPC policy 4.5.13 states, "Following an investigation conducted by the facility into a detainee's allegation of sexual abuse, the facility will notify the FOD of the results of the investigation and any responsive actions taken so that the information can be reported to ICE headquarters and to the detainee." An interview with the facility PREA Investigator indicated detainees are notified of the outcome of the investigation and any responsive action taken. The lead Auditor submitted a Notification to Detainee of PREA Investigation Results form to the ERAU TL for confirmation of the notifications and confirmed the detainees were notified of the outcomes and the responsive action taken following the conclusion of both investigations.

Corrective Action:

No corrective action needed.

§115.76 - Disciplinary sanctions for staff.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): PISPC policy 4.5.13 states, "Staff will be subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse rules, policies or standards. The agency will review and approve facility policies and procedures regarding disciplinary or adverse actions for staff and will ensure that the facility policy and procedures specify disciplinary or adverse actions for staff, up to and including removal from their position and from the Federal service, when there is a substantiated allegation of sexual abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Removal from their position and from the Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer, paragraphs (1)–(4) and (7)–(8) of the definition of ''sexual abuse of a detainee by a staff member, contractor, or volunteer'' in §115.6 of the Federal Register. Removal from their position is the presumptive disciplinary sanction for staff member, contractor or volunteer who have engaged in or attempted or threatened to engage in those acts of sexual abuse defined in paragraphs (a) - (d) and (g) - (h) of "Staff on Detainee Sexual Abuse and/or Assault" in "B. Acts of Sexual Abuse and/or Assault" in this policy. PISPC will report all incidents of substantiated sexual abuse by staff, and all removals of staff, or resignations in lieu of removal for violations of agency or facility sexual abuse policies, to appropriate law enforcement agencies unless the activity was clearly not criminal." The lead Auditor reviewed a memorandum to the file which states, "There were no records of termination, resignation, or other sanctions against staff members for violating the agency sexual abuse/assault policies during the reporting period." Interviews with the FD and HRM indicated staff are subject to discipline, including removal from their position with federal service if they engage in sexual abuse or violation the SAAPI policy. Interviews with the FD and HRM further indicated staff would be moved to a post that does not have contact with detainees or placed on administrative leave pending the results of the investigation. In addition, interviews with the FD and HRM confirmed they would notify any licensing body necessary if a licensed staff member is removed or resigns in lieu of removal for violating the facility sexual abuse policies. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither included a staff member. The lead Auditor reviewed PISPC policy 4.5.13 and confirmed the policy was 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): PISPC policy 4.5.13 states, "Any contractor or volunteer who has engaged in sexual abuse will be prohibited from contact with detainees. The facility will 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 will also be reported to the FOD and law enforcement agencies unless the activity was clearly not criminal. The facility will take appropriate remedial measures and will consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within these standards." The lead Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center did not identify any incidents of a contractor/volunteer violating the sexual abuse/assault policies during the reporting period." Interviews with the FD and PSA Coordinator/PSA Compliance Manager indicated any contractor or volunteer suspected of perpetrating sexual abuse would be removed from all duties involving detainee contact, law enforcement would be notified, and the incident would be reported to the contractor's employer and any other licensing bodies. Interviews with the FD and PSA Coordinator/PSA Compliance Manager further indicated if a contractor violated any other provisions of facility policies, they would be removed from the facility and any further contact with detainees, pending the results of an investigation. The Auditor reviewed two sexual abuse allegation investigation files and confirmed neither of the files involved a contractor or a volunteer.

Corrective Action:

No corrective action needed.

§115.78 - Disciplinary sanctions for detainees.
Outcome: Does Not Meet Standard
Notes:

(a)(b)(c)(d)(e)(f): PISPC policy 4.5.13 states, "Detainees will be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault. Any sanctions imposed will be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. The facility holding detainees in custody will have a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure. If a detainee is mentally disabled or mentally ill but competent, the disciplinary process will consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The facility will 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 or assault made in good faith based upon a reasonable belief that the alleged conduct occurred will not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." The lead Auditor reviewed a memorandum to the file which states, "The Port Isabel Detention Center has no record demonstrating that disciplinary sanctions were imposed on a detainee found to have engaged in sexual abuse during the reporting period." An interview with the facility Disciplinary Officer indicated the facility does have a formal disciplinary process with progressive levels of review, appeals, and documentation procedures. An interview with the facility Disciplinary Officer further indicated disciplinary hearings are conducted by a Disciplinary Panel, which consists of a facility Captain, a Lieutenant, and a facility Detention Officer. In addition, in an interview with the Disciplinary Officer it was indicated a detainee would not be disciplined for sexual contact with staff unless there is a finding the staff member did not consent or disciplined for allegations made in good faith and a detainee's mental illness and how it may have contributed to the behavior is considered during the disciplinary process. The Auditor reviewed two sexual abuse allegation investigation files and confirmed both investigative findings were unsubstantiated; however, each file had disciplinary documents which confirmed the alleged perpetrator had been disciplined at the time of the allegation and not following an administrative or criminal finding that the detainee

engaged in sexual abuse. The Auditor conducted a follow-up interview with the Disciplinary Officer and confirmed the facility's practice was to initiate a misconduct report for the highest charge available, assault which includes sexual abuse and not following an administrative or criminal finding the detainee engaged in sexual abuse 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 two sexual abuse allegation investigation files and confirmed both investigative findings were unsubstantiated; however, each file had disciplinary documents which confirmed the alleged perpetrator had been disciplined at the time of the allegation and not following an administrative or criminal finding that the detainee engaged in sexual abuse. The Auditor conducted a follow-up interview with the Disciplinary Officer and confirmed the facility's practice was to initiate a misconduct report for the highest charge available, assault which includes sexual abuse and not following an administrative or criminal finding the detainee engaged in sexual abuse as required by subsection (a) of the standard. To become compliant, the facility must develop, and implement, a process to ensure detainees are subject to disciplinary sanctions pursuant to formal disciplinary process following an administrative or a criminal finding the detainee engaged in sexual abuse. Once implemented the facility must submit documentation to confirm all applicable staff, to include all staff involved in the disciplinary process, receive training on the implemented procedure. If applicable, the facility must submit all sexual abuse allegation investigation files, and the corresponding disciplinary documentation, to confirm the alleged detainee perpetrator is not issued a misconduct report unless the alleged sexual abuse is substantiated.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "If screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff will, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee will receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee will receive a mental health evaluation no later than seventy-two (72) hours after the referral." IHSC Directive 03-10 states, "Behavioral health referrals are made in accordance with the IHSC Behavioral Health Services Guide. If a detainee discloses a history of sexual victimization or abuse during a medical or mental health intake screening, whether it occurred in an institutional setting or in the community, a referral to mental health or an MLP should be made immediately. If, at any time during the intake screening or review, a detainee requests, or there appears to be, a need for mental health services, the nurse will notify the Health Services Administrator (HSA) as soon as possible, or within 24 hours." Interviews with a Classification Officer and an Intake Officer indicated if during the initial risk assessment, a detainee discloses previous sexual abuse or has perpetrated sexual abuse, intake staff will complete the "Detainee requires Medical/Mental Health Assessment" on the Detainee Classification Risk Assessment form. The lead Auditor reviewed the facility Detainee Classification Risk Assessment, and confirmed it includes a section to note if a detainee requires a Medical/Mental Health Assessment. A review of the facility Detainee Classification Risk Assessment further confirms the form states, "(Referral must be made within 48 hours of intake. Shift Supervisors must be notified prior to housing.)" In an interview with the Classification Officer, it was indicated once the form is completed a phone call is immediately made to medical staff to let them know a referral needs to be completed. In an interview with the Intake Officer, it was indicated if a referral to medical or mental health staff is needed Intake staff will notify medical staff working in the intake. During the on-site audit, although requested, the facility could not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse based on the Detainee Classification Risk Assessment; and therefore, the lead Auditor could not confirm referrals to medical and/or mental health were being made immediately after being identified by the initial risk assessment pursuit to 115.41. An interview with the AHSA indicated, if a

referral is needed, staff will send an email to the medical assistant and other relevant staff, to include but not limited to the AHSA, and the PSA Coordinator/Compliance Manager. An interview with the AHSA further indicated, once the medical assistant receives the email a telephone encounter is entered into the medical computer system which notifies medical staff a detainee has been identified as a victim or abuser and the detainee will be seen by medical staff within two working days. An interview with a LCSW indicated once the telephone encounter has been initiated, she will see the detainee the same day or the following day; however, no later than 72 hours after the referral. During the on-site audit, although requested, the facility did not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse until medical provided a medical roster which included detainees who had been identified as sexual aggressors or victims of sexual abuse based on the initial medical assessment conducted during the intake process. However, as the medical roster was not provided until the exit interview the Auditor was unable to review medical and mental health files to confirm, a referral had been immediately initiated at intake or medical and mental health staff-initiated follow-ups with the detainees in the timeframes required by subsections (b) and (c) of the standard.

Corrective Action:

The facility is not in compliance with subsection (a), (b), and (c) of the standard. The lead Auditor reviewed the facility Detainee Classification Risk Assessment and confirmed the form requires, "Referral must be made within 48 hours of intake." During the on-site audit, although requested, the facility could not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse based on the Detainee Classification Risk Assessment; and therefore, the lead Auditor could not confirm referrals to medical and/or mental health were being made immediately after being identified by the initial risk assessment pursuit to 115.41. During the on-site audit, although requested, the facility did not provide the lead Auditor with rosters of detainees who had been identified as likely to be sexual aggressors or victims of sexual abuse until medical provided a medical roster which included detainees who had been identified as sexual aggressors or victims of sexual abuse based on the initial medical assessment conducted during the intake process. However, as the medical roster was not provided until the exit interview the Auditor was unable to review medical and mental health files to confirm, a referral had been immediately initiated at intake or medical and mental health staff-initiated follow-ups with the detainees in the timeframes required by subsections (b) and (c) of the standard. To become compliant, the facility must implement a practice which requires a detainee who has experienced prior sexual victimization or perpetrated sexual abuse, is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate and when a referral for medical follow-up is initiated, the detainee receives a health evaluation no later than two (2) working days from the date of assessment or when a referral for mental health follow-up is initiated, the detainee receives a mental health evaluation no later than seventy-two (72) hours after the referral. Once implemented, the facility must submit documentation which confirms all applicable staff, to include Intake, Classification, medical, and mental health, have received training on the implemented practice. In addition, the facility must submit 10 detainee files, to include a detainee has been identified as a sexual aggressor or sexual abuse victim, and the corresponding medical and mental health records to confirm a detainee who has experienced prior sexual victimization or perpetrated sexual abuse, was immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate and when a referral for medical follow-up is initiated, the detainee receives a health evaluation no later than two (2) working days from the date of assessment or when a referral for mental health follow-up is initiated, the detainee receives a mental health evaluation no later than seventy-two (72) hours after the referral.

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

Outcome: Meets Standard

Notes:

(a)(b): PISPC policy 4.5.13 states, "Detainee victims of sexual abuse will have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually

transmitted infections prophylaxis, in accordance with professionally accepted standards of care." PISPC policy 4.5.13 further states, "Emergency medical treatment services provided to the victim will be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." IHSC Directive 03-01 states, "ICE has zero-tolerance for all forms of sexual abuse or assault. Victims of sexual abuse and sexual assault, with current or a history of sexual abuse or assault, have unimpeded access to immediate medical and behavioral health services. IHSC provides access to emergency medical and behavioral health services, and ongoing care, for detained noncitizens and residents (hereinafter known as patients) who are victims of sexual abuse or assault, and when deemed appropriate by mental health practitioners, detained noncitizen abusers. IHSC provides treatment services to patients without financial cost, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. IHSC recognizes the trauma related to sexual abuse and assault, and integrates trauma-informed approaches to detect, prevent, intervene, and reduce these events." IHSC Directive 03-01 further states, "Coordinates with ICE stakeholders to transport an alleged sexual abuse or assault patient to an outside facility for evaluation, medical care, and crisis intervention services. These services include emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." An interview with the AHSA indicated if a detainee were to be sexually abused at the facility, medical staff would triage the detainee, address any emergency medical issues, and then transport the detainee victim to VBMC for further evaluation and a SANE/SAFE examination where crisis intervention services would be offered. An interview with the AHSA further indicated medical staff would provide follow-up services to the detainee victim, to include sexually transmitted infections prophylaxis and all services are provided in accordance with professionally accepted standards of care, and regardless of if the detainee victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor spoke with a Registered Nurse (RN) working in the emergency room at VBMC and confirmed, if needed, VBMC would provide a certified examiner to conduct a SANE/SAFE examination and an advocate to provide crisis intervention services as needed. The Auditor reviewed two sexual abuse allegation investigation files and confirmed each detainee victim was seen by medical and mental health staff after reporting an incident of sexual abuse and a SANE/SAFE examination was not required following either allegation.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f)(g): PISPC policy 4.5.13 states, "The facility will offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. The evaluation and treatment of such victims will include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Emergency medical treatment services provided to the victim will be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility will provide such victims with medical and mental health services consistent with the community level of care. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated will be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim will 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 will be offered tests for sexually transmitted infections as medically appropriate. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." An interview with the AHSA indicated detainees would receive timely emergency access to medical and mental health treatment to include as appropriate, follow up tests for sexually transmitted infections, follow-up services, treatment plans, and, when

necessary, referrals for continued care following their transfer to or placement in, other facilities, or their release from custody in accordance with professionally accepted standards of care. An interview with the AHSA further indicated all treatment provided would be at no cost to the detainee victim of sexual abuse. In an interview with a LCSW it was indicated a detainee perpetrator of sexual abuse would receive an evaluation immediately upon learning of such abuse history and if the abuser is willing to participate a treatment plan would be established. During the on-site audit the lead Auditor spoke with a Registered Nurse working in the emergency room at VBMC and confirmed VBMC would provide emergency medical treatment, including emergency contraception and sexually transmitted infections prophylaxis. An interview with a Registered Nurse further confirmed a victim advocate is provided to accompany the detainee during the examination to provide emotional support, crisis intervention, and counseling. In addition, an interview with a Registered Nurse confirmed a SAFE/SANE examination would be completed at no cost to the detainee. The Auditor reviewed two sexual abuse allegation investigation files and confirmed the alleged detainee victims of sexual abuse were immediately referred to medical and mental health. A review of two sexual abuse allegation investigation files further confirmed neither alleged perpetrator was found to have perpetrated sexual abuse; and therefore, were not referred to mental health for evaluation and treatment.

Corrective Action:

No corrective action needed.

§115.86 - Sexual abuse incident reviews.

Outcome: Meets Standard

Notes:

(a)(b)(c): PISPC policy 4.5.13 states, "For any substantiated or unsubstantiated allegation, the facility will prepare a written report within thirty (30) days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and assault. PISPC will implement recommendations for improvement or document its reasons for not doing so in a written response. Both the report and response will be forwarded to the FOD, or his or her designee, for transmission to the ICE PSA Coordinator. The facility will also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator. The review team will 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. PISPC will conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility will prepare a negative report. The results and findings of the annual review will be provided to the AFOD and FOD, or his or her designee, for transmission to the ICE PSA Coordinator." An interview with the facility PREA Investigator/Incident Team Review Member indicated the facility has established a review team that consists of upper-level management and allows for input from custody staff, facility PREA Investigators, and medical and mental health practitioners. An interview with the facility PREA Investigator/Incident Team Review Member further indicated the facility utilizes a Sexual Abuse or Assault Incident Review form to document the review. In addition, an interview with the facility PREA Investigator/Incident Team Review Member indicated a review is completed within 30 days of the conclusion of the investigation. The lead Auditor reviewed the Sexual Abuse or Assault Incident Review form and confirmed the review team considers whether the incident or allegation was motivated by race; ethnicity; gender identity: lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The Auditor reviewed two sexual abuse allegation investigation files and confirmed each file contained a Sexual Abuse or Assault Incident Review form which had been completed within 30 days of the conclusion of the investigation with recommendations for improvement. A review of two sexual abuse allegation investigation files further confirmed both the review and responses were forwarded to the Agency PSA

Coordinator. The lead Auditor reviewed the 2023 Facility Annual Sexual Abuse and Assault Report and confirmed the report had been forwarded to the to the FD, FOD, and the Agency PSA Coordinator.

Corrective Action:

No corrective action needed.

§115.87 - Data collection.
Outcome: Meets Standard
Notes:

(a): PISPC policy 4.5.13 states, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and mental health evaluations and treatments, crisis intervention counseling and recommendations for post-release follow-up treatment and/or counseling will be retained in accordance with an established schedule of document retention." An interview with the facility PREA Investigator indicated all case records associated with allegations of sexual abuse are secured in a locked filing cabinets and the office doors are always locked in both his and the PSA Coordinator/Compliance Manager's Office. The Auditor observed the locked cabinet in the PREA Investigators office; however, could not observe the PSA Coordinator/Compliance Manager's Office as she was mostly unavailable at the time of the on-site audit.

Corrective Action:

No corrective action needed.

§115.201 - Scope of audits.
Outcome: Meets Standard
Notes:

(d)(e)(i)(j): During all stages of the audit, including the on-site audit, the Auditor was able to observe all areas of the facility and review all available policies and procedures, memos and other relevant documentation required to make an assessment on PREA Compliance. Interviews with staff and detainees were conducted in private while on-site and 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 detainees, outside entity, or staff correspondence was received prior to the on-site audit or during the post audit review.

Corrective Action:

No corrective action needed.

AUDITOR CERTIFICATION:

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

Robin Bruck 7/31/2024

Auditor's Signature & Date

(b) (6), (b) (7)(C) 8/19/2024

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 8/19/2024

Assistant Program Manager's Signature & Date

U.S. Immigration
and Customs
Enforcement

Office of Professional Responsibility