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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Sabina Kaplan	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	El Paso Field Office		
Field Office Director:	Kenneth Genalo		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	5441 Watson Dr., Albuquerque, NM 87106		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Torrance County Detention Facility		
Physical address:	209 County Road, A049		
Mailing address: *(if different from above)*	P.O. Box 837—Estancia, NM 87106		
Telephone number:	505-384-2711		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	George Dedos	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-384-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Chief of Security
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-404-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found Torrance County Detention Facility (TCDF) met 28 standards, had 0 standards that exceeded, had 2 standards that were non-applicable (115.14; 115.18), and had 11 non-compliant standards. As a result of the facility being out of compliance with 11 standards, the facility entered into a 180-day corrective action period which began on June 23, 2022 and ended on December 20, 2022. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Initially Not Met: 11

§115.16 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

§115.34 Specialized training: Investigations

§115.41 Assessment for risk of victimization and abusiveness

§115.42 Use of assessment information

§115.53 Detainee access to outside confidential support services

§115.65 Coordinated response

§115.76 Disciplinary sanctions for staff

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

§115.86 Sexual abuse incident reviews

The facility submitted documentation, through the Agency, for the CAP on August 1, through December 20, 2022. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on December 20, 2022, which included two closed sexual abuse investigative reports (not the entire investigative case file) and some records the Auditor requested. Based on the final review, the Auditor determined TCDF was compliant with five standards and remained non-compliant with six standards, as indicated below.

Number of Standards Met: 5

§115.34 Specialized training: Investigations

§115.42 Use of assessment information

§115.76 Disciplinary sanctions for staff

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

§115.86 Sexual abuse incident reviews

Number of Standards Not Met: 6

§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

§115.53 Detainee access to outside confidential support services

§115.65 Coordinated response

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence replied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable.

§115. 16 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): Policy 14-101 (Disability Identification Assessment and Accommodation) states, "Throughout the facility's programs and activities, including at all stages of the reasonable accommodation process, the facility must take appropriate steps to allow for effective communication with detainees with disabilities to afford them an equal opportunity to participate in, and enjoy the benefits of, the facility's programs and activities. Steps to ensure effective communication may include the provision and use of auxiliary aids or services for detainees with vision, hearing, sensory, speech, and manual impairments, as needed. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual detainee, the nature, length, and complexity of the communication involved, and the context in which the communication is taking place. In determining what types of auxiliary aids or services are necessary, the facility shall give primary consideration to the request of the detainee with a disability. Use of other detainees to interpret or facilitate communication with a detainee with a disability may only occur in emergencies. The facility shall provide detainees with disabilities with necessary accommodations in an expeditious manner. In many situations, the facility will be able to immediately grant a detainee's request for an accommodation. Referral to the multidisciplinary team (a healthcare professional and any additional facility staff with requisite knowledge of and/or responsibility for compliance with disability policies and procedures; the team may consist of two or more staff) may be appropriate for detainees who are identified as having a cognitive, intellectual, or developmental disability, including a traumatic brain injury. Facility staff should not require the detainee's participation in the assessment process and should be sensitive to the fact that some detainees in this category may not perceive themselves as having a disability. However, facility staff should provide appropriate assistance to a detainee with a cognitive, intellectual, or developmental disability, even if not explicitly requested (for example, reading and explaining a form to a detainee with limited cognitive abilities)." Policy 14-2 DHS states, "The facility shall ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse." The Auditor reviewed four detainee files submitted with the Pre-Audit Questionnaire (PAQ) that contained the detainee's booking information, completed Language Preference form, and SAAPI Education Acknowledgement form signed by the detainee; the acknowledgement form indicated that they had received the SAAPI and the facility's orientation, the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, the ICE National Detainee Handbook, and the PREA video. In addition, a Receiving & Discharge Checklist was provided to the Auditor acknowledging the detainee's receipt of the TCDF detainee handbook (only available in English and Spanish), ICE National Detainee Handbook, and facility PREA and DHS-prescribed Sexual Abuse Awareness Information pamphlets. The Auditor reviewed the provided documentation and confirmed based on the booking information that the four detainees were issued the PREA information, including the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Abuse Awareness Information pamphlet, and the facility and ICE National Detainee Handbook. In addition, the Auditor also confirmed that all information, with the exception of the facility detainee handbook, was delivered to all but one detainee in the detainee's preferred language. The facility provided the Auditor with a copy of the DHS-prescribed Sexual Abuse Awareness Information pamphlet in the following languages: English, Spanish, French, Hindi, Punjabi, Chinese, Arabic, Haitian Creole, and Portuguese. In addition, the facility provided a copy of the ICE National Detainee Handbook in English, Spanish, French, Portuguese, Arabic, Hindi, Punjabi, Haitian Creole, Chinese, Turkish, Romanian, Russian, and Vietnamese to the Auditor prior to the Auditor's facility visit. Throughout the on-site tour, the Auditor observed the ICE zero tolerance posters, DHS-prescribed Sexual Abuse Awareness Information pamphlets, consulate posters, and the RCC posters on housing unit bulletin boards in English and Spanish. The Auditor observed the PREA hotline and RCC numbers painted on the walls near the phones in the housing units and posted throughout the facility. The Auditor observed the PREA video playing in the intake holding cells in English and Spanish with closed caption. The Intake Coordinator advised that the PREA video is in English, Spanish, and French, and further stated that the video information is not translated into other languages, but she ensures detainees who speak other languages are provided the DHS-prescribed Sexual Abuse Awareness Information pamphlet and ICE National Detainee Handbook in their preferred language. The Intake Coordinator further stated if she needed additional DHS-prescribed Sexual Abuse Awareness Information pamphlets and ICE National Detainee Handbooks, she would immediately consult the Senior Detention Deportation Officer (SDDO) or any (Immigration and Customs Enforcement (ICE) staff who is assigned to the facility. The Auditor also observed that the ICE National Detainee Handbooks are provided in 14 different languages in the detainee tablets located in the housing units.

On the second day of the audit, the Auditor was able to observe the initial intake process. The facility received 31 new detainees who were all Limited English Proficient (LEP). Two medical nurses preliminarily screened each detainee by allowing the detainees to read a line of questions in their preferred language. The questions were translated in 12 different languages (English, Spanish, Portuguese, Turkish, Arabic, Chinese, Bangladesh, Haitian-Creole, Uzbek Farsi, Punjabi, Russian, and Sri Lanka) to determine if they needed immediate medical attention. Given the large number of intakes, the Auditor was only able to observe the entire intake process of two detainees. The Auditor observed that classification staff utilized a staff interpreter and the facility's interpretive language line to conduct the two detainees' initial screenings and provided them with a DHS-prescribed Sexual Abuse Awareness Information pamphlet and the ICE National Detainee Handbook in their preferred language. The Auditor observed that medical staff only utilized the facility's interpretive language line to conduct the PREA intake screening and to ensure the privacy of the detainees' medical status.

The interview with the facility investigator and a thorough review of five investigative files confirmed sexual abuse or sexual abuse interviews are conducted through the use of the facility interpretive language line when necessary. The facility investigator confirmed that three of five investigations required the use of the facility's interpretive language line.

During the audit, the Auditor conducted a total of 18 random detainee interviews. Of the 18, there was only one detainee who fluently spoke and understood English; the other 17 detainees spoke Spanish, Portuguese, Turkish, or Arabic. During their interviews with the Auditor, 11 detainees reported when they first arrived at TCDF, they were able to communicate with the facility staff during intake. Five detainees reported that although they were not able to effectively communicate with staff during intake, interpreter services via staff or the language line were provided. Two detainees reported that another detainee provided interpreter services during intake, but that medical provided such services via the interpretive language line. Twelve random detainees stated they needed interpreter and translation services to communicate with facility staff or read written materials in the facility and that facility staff provided the requested interpretation. In addition, all 17 LEP detainees reported they had been seen by medical during the intake process and that medical utilized the language line to conduct their assessment.

The Auditor conducted an interview with 10 random staff (7 DOs, 1 Captain, 2 Sergeants). All 10 random staff stated they have never communicated with a detainee who is deaf or hard of hearing, but that they would provide the detainee with the facility's information on sexual abuse prevention and response through written materials posted throughout the facility. In addition, the random staff stated they have never communicated with a detainee who is blind or has low vision but that they would read written materials to such detainees and provide them with audible video. All random staff reported they have never communicated with a detainee who has intellectual, psychiatric, or speech disabilities, and if they did, they would speak slowly and clearly to the detainee to provide the detainee with the facility's written information on sexual abuse prevention and response. Also, all 10 random staff reported they have communicated with a detainee who is limited in their ability to speak or understand English and that they have used the facility's language line to read TCDF's written materials regarding sexual abuse prevention, intervention, and response, as well as having provided the detainee with the ICE and SAAPI pamphlet in their own language. Likewise, the 10 random staff reported they would not use another detainee, the alleged abuser, a detainee witness, or a detainee who has a significant relationship to the alleged abuser to interpret any incidence of sexual abuse. In addition, the Auditor confirmed during the onsite audit review that should a detainee require a language other than English or Spanish, the tablets in the housing units provide the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese**,** and Vietnamese). During the interview, the PSA Compliance Manager stated that the facility provides impartial and accurate accommodations such as in-person (staff interpreter) and telephonic (language line) interpretive services to detainees with communication-related disabilities or who are LEP. Also, the PSA Compliance Manager stated that the facility provides written information about sexual abuse to detainees through the facility's detainee handbook and postings located on the housing unit bulletin boards. The PSA Compliance Manager also verified that the facility provides assistive devices such as a teletypewriter (TTY) (located in the Unit Manager's office) and a closed-captioned PREA video for detainees who are deaf or hard of hearing. The PSA Compliance Manager also stated that the PREA video's audio is used for those detainees who are blind or have low vision.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard, which requires that the facility ensure that LEP detainees have meaningful access to all aspects of the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The facility provides the detainee with an orientation video during orientation, and on the housing pods, which contains information regarding the facility's efforts to prevent, detect, and respond to sexual abuse; however, the RCC notifications and video is only available in French, English and Spanish. In addition, the facility also provides the RCC contact information through postings on the housing pods and in the TCDF Detainee handbook; however, this information is available only in English and Spanish. Interviews with staff could not confirm that the PREA information available to detainees in the orientation video is accessible to LEP detainees in a manner that they could understand. To become compliant, the facility must develop a practice that would allow LEP detainees who do not speak French, English or

Spanish access to the PREA information provided by the facility on the orientation video. In addition, the facility must provide the RCC contact numbers in a manner detainees who do not speak English or Spanish can understand. Once developed, all Intake staff must receive documented training on the new procedures and the facility must present the Auditor with 10 detainee files that are for detainees who speak languages other than English or Spanish to confirm that the detainees are getting the video information and RCC contact numbers in a format they understand.

Corrective Action Taken (b): Although the facility provided documentation that staff were trained on new procedures which included understanding interpreter requirements to provide LEP detainees access to the PREA information contained within the orientation video and the RCC contact numbers in a manner they could understand, they did not provide documentation that the new procedures requiring interpretation of the orientation video and the RCC contact numbers in a manner the detainee could understand had actually been implemented. Instead of implementing the procedures to provide the interpretation, the facility submitted written documentation that states, "An agency or facility is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or [an] undue financial and administrative burdens. Requiring the production of a significant number of orientation videos in languages based only on possible al arrival of a detainee who might speak that language would pose a burden on the facility." Although the Auditor agrees with this statement, the facility can achieve the same results by having the PREA portion of the video translated into the most prevalent languages used by ICE and/or having the PREA portion of the video translated by the language line during the orientation process. In addition, the facility did not provide a memo confirming no detainees were processed who speak languages other than English, Spanish or French, and arrived on different dates, to confirm receipt of video information and RCC contact numbers in a format that they understand as required by the Auditor. Upon review of the submitted documentation, which did not include confirmation that new procedures were implemented to provide all LEP detainees access to the PREA information provided through the orientation video and the RCC contact numbers in a manner they could understand, the Auditor continues to find the facility does not meet subsection (b) of the standard.

§115. 22 - Policies to ensure investigation of allegations and appropriate agency oversight
Outcome: Does not Meet Standard
Notes:

(a)(b)(d)(e)(f): The Agency provided a written directive, Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, which states, "When an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (b) (6), (b) (7)(C) 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)." Furthermore, Policy 14-2 DHS states, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators." Policy 14-2 DHS further states, "At this facility, the following law enforcement agencies are notified in accordance with PREA standard 115.22: Estancia Police Department, 1000 Highland Avenue, Estancia NM. When a detainee, of the facility in which an alleged detainee victim is housed, is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director/designee. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director/designee, and to any local government entity or contractor that owns or operates the facility", and "retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years." The Warden confirmed the policy outlining the investigation protocols was reviewed and approved by ICE and provided this documentation to the Auditor. The PSA Compliance Manager stated that upon receiving a report of sexual abuse, the facility investigator immediately makes a referral to the Estancia Police Department (EPD) if there is a criminal component, and the facility investigator conducts the administrative investigation. The facility's investigator stated that for each sexual abuse allegation received, the facility leaders (Chief of Security, unit management, mental health, medical, and corporate office) have a meeting within 72 hours to determine if the allegation is criminal in nature and if determined so, EPD is immediately notified. The facility's investigator further stated that if the EPD does not accept the case, EPD then notifies the TCDF. In an interview with the PSA Compliance Manager, it was indicated that if the allegation is not criminal in nature, the facility investigator would conduct an administrative investigation. The Auditor

conducted a thorough review of five of the eight allegations reported within the audit period. Of the five reviewed allegations in the investigative files, the Auditor was able to confirm that all five allegations were reported to ICE ERO; however, one case could not confirm that the JIC was notified. In addition, a review of the PREA allegation spreadsheet indicated that eight closed cases were referred to the ICE ERO; however, four were not referred to the JIC by the facility protocol and standard.

Does Not Meet (e)(f): The facility is not in compliance with subsections (e) and (f) of the standard. A review of the PREA allegation spreadsheet and five investigative files indicated that the facility reported the cases to the ICE ERO; however, neglected to report four allegations of sexual abuse, including two against a staff member, to the JIC, ICE OPR or the DHS OIG. To become compliant, the facility must provide documentation, if available, that all incidents of sexual abuse are reported as dictated by the standard. This can be achieved through documentation of any future sexual abuse allegations at the facility. In addition, the PSA Compliance Manager and other involved upper management staff must receive documented training regarding their responsibility to report all incidents of sexual abuse to the appropriate entities.

Corrective Action Taken (e)(f): The facility submitted an email to the Auditor confirming that an allegation of sexual abuse that occurred at Torrance was reported to the JIC; however, the email confirmation was for an allegation that was confirmed to have been submitted to the JIC already, and not for one of the four allegations of sexual abuse, including two against a staff member in question, that were identified previously as unreported. The facility provided the Auditor with two sexual abuse allegation investigation reports that occurred during the CAP period; however, upon review of the PREA allegation spreadsheet depicting allegations to have occurred at TCDF during the CAP period and reported to the JIC, it was confirmed that only one of the sexual abuse allegations was reported to the JIC. Upon review of all submitted documentation, which includes a copy of a sexual abuse allegation investigation that occurred during the CAP period that was not reported to the JIC, the Auditor continues to find that the facility does not meet subsections (e) and (f) of the standard.

§115. 33 - Detainee education
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(d)(e)(f): Policy 14-2 DHS states, "During the intake process, all detainees shall be notified of the facility zero tolerance policy on sexual abuse and assault. Detainees will be provided with information (orally and in writing) about the facility's SAAPI Program. Such information shall include, at a minimum: The facility's zero tolerance policy for all forms of sexual abuse or assault; Prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; Explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS/Office of Inspector General (OIG) and the ICE/Office of Professional Responsibility (OPR) investigation processes; Information about self-protection and indicators of sexual abuse and assault; Prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceeding and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." During the on-site audit the Auditor observed the entire intake/classification process of two detainees in which the intake staff informed the detainees of the facility's zero tolerance policy for all forms of sexual abuse. Also, the Auditor observed the PREA video playing in English and Spanish with closed captioning. The video addresses the following topics: 1) prevention and intervention strategies; 2) definitions and examples of detainee-on-detainee sexual abuse and coercive sexual activity; 3) reporting methods; 4) self-protection and indicators of sexual abuse; 5) retaliation; and 6) detainees' right to be free from sexual abuse." Policy 14-2 DHS further states, "The facility shall post on all housing unit bulletin boards the following notices: The DHS-prescribed sexual abuse and assault awareness notice, the name of the facility PSA Compliance Manager, and information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available). If no such local organizations exist, the facility shall make available the same information about national organizations. The facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities" and "the facility shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information pamphlet." In addition, Policy 14-2 DHS states, "The facility shall maintain documentation of detainee participation in educational sessions pertaining to sexual abuse." In an interview, the Intake Coordinator stated that the detainee orientation program on sexual abuse prevention consists of the PREA video, DHS-prescribed Sexual Assault Awareness Information pamphlet, distribution of the ICE National Detainee Handbook, and facility detainee handbooks. According to the Intake Coordinator, the orientation program includes the following: TCDF's zero tolerance policy, prevention and intervention strategies, definitions, and examples of sexual abuse (both detainee and staff), multiple ways to report sexual abuse (any staff member, DHS OIG, self-protection methods, indicators of sexual abuse, prohibition against retaliation, and the right to treatment and counseling for detainee victims). The Intake Coordinator further advised that the PREA video is in English, Spanish, and French, and that she ensures detainees who speak other languages are provided the SAAPI pamphlet and ICE National Detainee Handbook in

their preferred language. The Intake Coordinator stated that the orientation program on sexual abuse is accessible to detainees who are deaf or hard of hearing through written materials such as the facility detainee handbook, ICE National Detainee Handbook, the DHS-prescribed Sexual Assault Awareness Information pamphlet, and a closed captioned PREA video. Also, the Intake Coordinator reported that the orientation program on sexual abuse is available to detainees who are limited in their ability to speak or understand English through the facility's language line, translated materials (TCDF handbook, ICE Detainee Handbook, SAAPI pamphlet), and staff interpreters. In addition, the Intake Coordinator stated that the orientation program on sexual abuse is accessible to detainees who are blind or who have low vision through audio materials available (video) and staff available to read to detainees. The Intake Coordinator also stated that the orientation program on sexual abuse is available to detainees who have intellectual, psychiatric, or speech disabilities; intake staff would read the orientation video transcript and DHS-prescribed Sexual Assault Awareness Information by speaking slowly and clearly and referring the detainees to mental health staff for assistance. According to the Intake Coordinator, the facility's orientation program on sexual abuse is accessible to detainees who have limited reading skills through audible videos and staff reading the information to them. The Auditor also observed that the ICE National Detainee Handbooks are provided in 14 different languages in the detainee tablets located in the housing units. The Warden stated in his interview that the facility has never been unable to provide an accommodation requested by a detainee with a disability. The Auditor reviewed a copy of the video script provided with the PAQ and confirmed it contained all elements required in subsection (a) of the standard.

The Auditor reviewed four detainee files submitted with the PAQ that contained the detainees' booking information, completed Language Preference forms, and SAAPI Education Acknowledgement forms, signed by the detainee indicating that they had received the facility's orientation, the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, the ICE National Detainee Handbook, and viewed the PREA video. In addition, a Receiving & Discharge Checklist was provided to the Auditor acknowledging the detainees' receipt of the TCDF detainee handbook, ICE National Detainee Handbook, the facility PREA and DHS-prescribed Sexual Assault Awareness Information pamphlets. The Auditor reviewed the provided four detainee files and confirmed based on the booking information that detainees were received at TCDC on February 5, 2022; January 20, 2022; August 4, 2021; and September 30, 2021, and each detainee completed orientation and was issued the PREA information, including the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, and the facility and ICE National Detainee Handbook on February 8, 2022; January 22, 2022; August 4, 2022; and October 4, 2021, respectively. The signed acknowledgement also indicated that all detainees viewed the orientation PREA video; however, the video is not offered in two of the detainee's preferred language, nor according to the Intake Coordinator, was it translated to the detainees. In addition, the documentation provided indicated that the fourth detainee did not receive the written PREA information in his preferred language.

Seventeen detainees confirmed when they first arrived at TCDF, they remember receiving information about sexual abuse such as how to stay safe or report an incident of sexual abuse through a staff interpreter, facility detainee handbook in their own language, the SAAPI pamphlet, or hotline information on posters. Three detainees who spoke either Arabic, Portuguese, or Turkish reported that the sexual abuse information was not provided to them in their language and the Auditor confirmed through detainee file review. The Auditor observed the RCC pamphlets posted throughout the housing units and in the intake/classification area in English and Spanish. The Auditor observed the DHS-prescribed sexual assault awareness notices, the name of the PSA Compliance Manager, OIG, PREA hotline, and the RCC posters located on the bulletin boards in the housing units, kitchen, and intake areas.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. Documentation provided with the PAQ confirmed that the orientation process is not completed during the intake process as required by subsection (a) of the standard. The Auditor reviewed the provided documentation and confirmed, based on the booking information, three out of four detainees did not complete orientation or receive the PREA information, including the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, and the facility and ICE National Detainee Handbook during the initial intake. Per the Intake Coordinator, the detainee orientation program on sexual abuse prevention consists of the PREA video, SAAPI pamphlet, and distribution of the ICE and facility detainee handbooks. The Intake Coordinator further stated that the orientation video is played in English, Spanish, or French and if a detainee's preferred language is something other than provided by the video, then the detainee would not get the information provided during the video presentation; and therefore, the facility is not compliant with subsection (b) of the standard. To become compliant, the facility must develop a practice that ensures that the detainee orientation is offered and completed during intake. In addition, the facility must have the video script translated and provided to detainees who do not speak English, Spanish, or French at intake. The facility must train all intake staff on the new practice and document such training. In addition, the facility must provide the Auditor with 10 detainee intake files consisting of different languages and different days, to confirm that the orientation is offered and completed during the intake process and that the video is understood by detainees who speak other than English, Spanish, and/or French.

Corrective Action Taken (a)(b): The facility did not provide documentation that confirmed a new practice had been implemented ensuring that the detainee orientation is offered and completed during intake or that the video script has been translated and provided to detainees who do not speak English, Spanish, or French. The facility did not provide a memo confirming no detainees were processed who speak languages other than English, Spanish or French, and arrived on different dates, to confirm orientation is offered and completed during intake or that the orientation video is offered to the detainee in a language the detainee understands. Upon review of the provided documentation, the Auditor continues to find the facility does not meet subsection (a) and (b) of the standard.

§115. 34 - Specialized training: Investigations

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

Notes:

(a)(b): Policy 14-2 DHS states, "The facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training covers, 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. Documentation confirming that investigators have completed the required specialized training in conducting sexual abuse investigations shall be maintained in accordance with CoreCivic Policies 1-15 Record Retention and 4-2 Maintenance of Training Records." The Agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement.

Prior to the Auditor's visit of the facility, the facility provided the Auditor with a copy of the facility investigator's training certificate confirming completion of the five-hour PREA Specialized Investigations course provided by the Moss Group, Inc. and through the PREA Resource Center's training portal. The facility also provided a copy of the Facility Investigator Onboarding certificate from CoreCivic confirming the facility investigator's completion of the training. The Auditor reviewed the PREA allegation spreadsheet and noted three facility investigators listed as assigned to conduct investigations; however, the facility only provided documentation that confirmed compliance for one.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of the PREA allegation spreadsheet confirms that the facility utilized three facility investigators to complete sexual abuse allegation investigations during the audit period; however, the facility only provided the Auditor with documentation that one facility investigator was trained. To become compliant, the facility must provide documentation that all staff assigned to conduct facility investigations have been trained in accordance with subsection (a) of the standard. In addition, the facility must provide copies of all sexual abuse investigations that occur during the CAP period to confirm the staff investigating the allegation has received the required training.

Corrective Action Taken (a): The facility submitted training certificates to confirm that the three investigators noted on the PREA allegation spreadsheet were trained in accordance with subsection (a) of the standard. In addition, the facility provided the Auditor with a copy of two sexual abuse allegation investigation reports that occurred during the CAP period which confirmed the investigator completing the investigation had received specialized training. Upon review of the submitted documentation, the Auditor now finds the facility is compliance with subsection (a) of the standard.

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

Outcome: Does not Meet Standard

Notes:

(b): Policy 14-2 DHS states, "The initial classification process and initial housing assignment should be completed within twelve (12) hours of admission to the facility." The Supervisor Post Order states, "at this facility, the shift supervisor's duties regarding intake/release/transfer procedure ensure detainees are not in holding cells for more than 12 hours." However, Policy 14-2 DHS further states, "Upon arrival at a facility, transgender/intersex detainees shall be temporarily housed in a location away from the general population (to include a medical unit or protective custody unit) for no more than seventy-two (72) hours (excluding weekends, holidays, and exigent circumstances) until classification, housing, and other needs can be assessed." The Intake Coordinator stated that initial classification is conducted within 12 hours of

admission to facility and prior to assigning detainees to a housing unit. Prior to the Auditor's visit of the facility, the facility provided the Auditor with the PAQ and a completed ICE Initial Screening Tool, which contained all required elements of the standard. According to the Intake Coordinator's interview, staff use the information from the ICE Initial Screening Tool and the Booking Questions form to assess the detainee's risk for sexual victimization or abusiveness, and to make housing and other classification decisions. However, the Auditor reviewed four detainee files submitted with the PAQ that contained the detainees' booking information and the TCDC Receiving and Discharge Checklist. A review of the information provided indicated that one detainee was received at TCDC on February 5, 2022, one detainee was received on January 20, 2022, one detainee was received on August 4, 2021, and one detainee was received on September 30, 2021. The Auditor further confirmed that the first detainee received his initial housing assignment on February 8, 2022; the second detainee received his initial housing assignment on January 22, 2022; the third detainee received his initial housing assignment on August 4, 2021; and the fourth detainee received his initial assignment on October 4, 2021. The Auditor further confirmed that the detainee who arrived on September 30, 2021, and was not assigned initial housing until October 4, 2021, self-identified as transgender. All detainees were listed as Reception Admission, Initial confirming that they had yet to be classified and assigned initial housing. In addition to the documentation submitted with the PAQ, the Auditor conducted 10 detainee file reviews while at the facility; those 10 indicated that the detainee had received an initial screening within 12 hours.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. The Auditor reviewed a total of four completed initial screenings conducted by intake staff at TCDF and confirmed that three screenings reflected completion well past the standard's requirement. The Auditor further confirmed that the detainee who arrived on September 30, 2021, and was not assigned initial housing until October 4, 2021, self-identified as transgender. In addition, Policy 14-2 DHS allows for staff to hold transgenders for up to 72 hours to complete the initial classification process and determine initial housing. To become compliant, the facility must develop a practice that requires the facility complete initial classification and initial housing assignments within 12 hours for all detainees, including transgender detainees, as required by the standard. In addition, the facility must train all applicable staff on the new practice and document such training. The facility must provide the Auditor with 10 detainee files consisting of 10 different days verifying that the detainee's initial intake and housing assignment was completed within in 12 hours. If applicable, the facility must also provide the Auditor with any detainee files that included a transgender detainee to confirm that the transgender detainee's initial classification and housing in assignment was completed within 12 hours as required by the standard.

Corrective Action Taken (b): The facility provided the Auditor with a copy of Policy 14-2-DHS, Sexual Abuse Prevention and Response, which states, "The initial classification process and initial housing assignment should be completed within twelve (12) hours of admission to the facility." In addition, the facility submitted documentation that all applicable staff were trained on the policy. The facility provided the Auditor with 10 detainee files from 10 different days, 7 of which confirmed initial classification and housing was completed within 12 hours of admission. In addition, the facility submitted to the Auditor a memorandum that states, "There have been no transgender or intersex detainees housed at Torrance County Detention Center during the CAP period." Upon review of the submitted documentation, the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

(e): Policy 14-2 DHS states, "The facility shall 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." The Intake Coordinator stated that a detainee's risk of victimization or abusiveness is reassessed between 60 and 90 days from the date of their 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. During the 10 detainee file reviews, 2 of the 10 detainees' files were for detainees housed at TCDF for more than 90 days and staff did not perform a reassessment of sexual victimization within the standard requirement of 60-90 days. One detainee's reassessment occurred at day 94 and the second detainee's reassessment occurred at day 103. In addition, a review of five investigative files could not confirm that the facility completed a reassessment following an incident of sexual abuse.

Does Not Meet (e): Although the facility conducted a reassessment of two detainees who had been in the facility past 90 days, the facility did not conduct the reassessments within 60-90 days. In addition, a review of five investigation files could not confirm that the facility conducted a reassessment following an incident of sexual abuse. To confirm compliance, the facility must provide the Auditor, if applicable, with copies of 10 detainee reassessments that occurred with 60-90 days from the date of their initial assessment that occurred during the CAP period. In addition, the facility must provide the Auditor with all sexual abuse allegation investigations that occur during the CAP period to confirm that reassessments are being conducted following an incident of sexual abuse. The facility must also train all applicable staff on the standard's requirements to conduct risk reassessments of detainees within 60-90 days and after an incident of sexual abuse and provide documentation confirming that said staff have received such training.

Corrective Action Taken (e): The facility provided the Auditor with 10 detainee files that confirmed 8 of 10 detainee reassessments were completed between 60 and 90 days. In addition, the facility submitted documented staff training entitled 60–90-day assessments. The facility further provided the Auditor with a copy of two sexual abuse allegation investigative reports that occurred during the CAP; however, the facility did not provide the Auditor with copies of the corresponding reassessments of the detainee victims who reported the allegations. Upon review of the submitted documentation, the Auditor continues to find that the facility does not meet subsection (e) of the standard.

§115. 42 - Use of assessment information

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

Notes:

(a): Policy 14-2 DHS states, "The facility shall use the information from the 14-2B-DHS Sexual Abuse Screening Tool conducted at initial screening in the consideration of housing recreation, work program and other activities." The Intake Coordinator stated that intake staff make individualized assessments for housing and classification decisions. In an interview, the Classification Supervisor indicated assignments are made for work and housing based on each individual detainee's risk assessment. The Auditor reviewed 10 detainee detention files, in which the DHS Sexual Abuse Screening Tool is kept. The files demonstrated initial risk assessments were conducted on each detainee to determine initial housing assignments; however, the files did not confirm that the information from the DHS Sexual Abuse Screening Tool is considered when determining recreation and other activities, and voluntary work.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41 when determining initial housing, recreation and other activities, or voluntary work assignments. A review of 10 detainee files could not confirm that this information is considered when determining recreation and other activities, or voluntary work assignments. To become compliant, the Initial DHS Sexual Abuse Screening Tool needs to be shared with staff determining recreation, volunteer programming and other activities so that the detainee's risk of sexual abuse can be taken into account. In addition, all Intake and other applicable staff should be trained in the proper use of the Initial ICE Screening Tool when determining the elements of the standard. The facility must also provide 10 detainee files that document that the information from the risk screening is utilized when determining initial housing, recreation, and other activities.

Corrective Action Taken (a): The facility submitted documentation of staff training entitled how to utilize the ICE screening tool that states, "All detainees will be assigned housing, recreation and other activities, or voluntary work assignments based on their classification level. In addition, the facility submitted to the Auditor a copy of the Offender Management System, The Torrance County Detention Center Detainee Alert screen, that confirms that the facility takes into account information from the ICE Screening Tool when determining all elements of the standard. Based on the documentation submitted, the Auditor no longer requires the facility to submit 10 detainee files to confirm compliance. Upon review of all submitted documentation, the Auditor now finds facility is in compliance with subsection (a) of the standard.

(b)(c): Policy 14-2 DHS states, "The facility should not base housing and program placement decisions for 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 shall always be taken into consideration. The facility shall make individualized case-by-case determinations about how to ensure the safety of each detainee." Policy 14-2 Policy 14-2 DHS further states, "Upon arrival at a facility, transgender/intersex detainees shall be temporarily housed in a location away from the general population (to include a medical unit or protective custody unit) for no more than seventy-two (72) hours (excluding weekends, holidays, and exigent circumstances) until classification, housing, and other needs can be assessed." The Intake Coordinator stated that the facility conducts risk assessments and makes housing determinations for transgender or intersex detainees taking into account the detainee's gender self-identification and the detainee's self-assessment of safety needs. The Intake Coordinator further stated the facility assesses the effects of placement on the detainee's health and safety and that the Intake staff would immediately consult with a medical or mental health professional on assessment so that they can make a decision that is consistent with the safety and security considerations of the facility. The Intake Coordinator further indicated that the facility will reassesses the decision at least twice a year. The Auditor reviewed one transgender detainee file submitted with the PAQ and confirmed the transgender detainee was released prior to the required reassessment date; however, a review of the file could not confirm the transgender detainee's housing was determined following consultation with a medical or mental health professional. In an interview with the Intake Coordinator, and random staff, it was indicated that transgender and intersex detainees are given the opportunity to shower separately from other detainees at intake/processing, when operationally feasible.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. The Auditor reviewed the submitted detainee file of a transgender detainee and could not confirm that the facility consulted a medical or mental health professional as soon as practicable regarding the transgender detainee's initial housing assessment. To become compliant,

the facility must train all intake, medical, and mental health staff regarding the requirement to consult a medical or mental health professional as soon as practicable regarding the transgender detainee's initial housing assessment. In addition, if applicable, the facility must submit any transgender detainee's detention files, medical files, and mental health files to confirm compliance with subsection (b) of the standard.

Corrective Action Taken (b): The facility submitted training documentation that confirmed all intake, medical, and mental health staff received training regarding the requirement to consult a medical or mental health professional as soon as practicable regarding the transgender or intersex detainee's initial housing assessment. In addition, the facility provided the Auditor with a memorandum that states, "There have been no transgender or intersex detainees housed at Torrance County Detention Center during the CAP period." Upon review of the submitted documentation, the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

§115. 53 - Detainee access to outside confidential support services

Outcome: Does not Meet Standard

Notes:

(d): Policy 14-2 DHS states, "The facility shall require that agencies providing confidential support services inform detainees, prior to rendering services, of the extent to which communications shall be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." Prior to the Auditor submitting the test call to the RCC, the telephonic automation informed the Auditor that the call may be monitored; however, the telephonic communication, facility posting, or the TCDF Detainee handbook advises the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws as required by subsection (d) of the standard.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. Prior to the Auditor submitting the test call to the RCC, the telephonic automation informed the Auditor that the call may be monitored, however, the telephonic communication, facility posting, nor the TCDF Detainee handbook advises the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws as required by subsection (d) of the standard. To become compliant, the facility must advise the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. The facility should also ensure this advisement process accounts for detainees that speak a language other than English and Spanish.

Corrective Action Taken (d): The facility submitted a memorandum to all detainees, dated 12/13/2022, in English and Spanish explaining the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws; however, the facility did not provide any documentation that would explain the information to detainees who speak a language other than English or Spanish. Upon review of the submitted documentation, the Auditor continues to find that the facility does not meet subsection (d) of the standard.

§115. 65 - Coordinated response

Outcome: Does not Meet Standard

Notes:

(c)(d): Policy 14-2 DHS states, "If a victim of sexual abuse is transferred between facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." Interviews with the Warden and HSA confirmed that, if they were to transfer a victim of sexual abuse, all proper notifications would be made in accordance with the policy. The Warden, and PSA Compliance Manager, in their interviews, confirmed that TCDF had no instances of victim transfers between DHS or non-DHS facilities within the previous 12 months. A review of the TCDF policy 14-2 DHS indicated that the facility is not in compliance with subsections (c) and (d) of the standard. The standard requires a coordinated plan that includes, "if a victim of sexual abuse is transferred between facilities covered by subpart A or B of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medial or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise" which is not covered in either the plan or the policy. In an interview with the facility Commander, he indicated that he "assumed subsections (c) and (d) would be handled by ICE," thus confirming the facility has not included sections (c) and (d) in their coordinated response.

Does Not Meet (c)(d): The facility's policy 14-2 DHS, which doubles as their coordinated response plan, does not include the requirements mandated by subsections (c) and (d) of the standard. To become compliant, the facility must update the policy 14-2 DHS to include the language required by subsections (c) and (d) of the standard and to initiate the practice of informing the receiving facility covered by subpart (a) and (b) of the incident and the victim's potential need for medial or

social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, informing the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise." The facility must also conduct documented training of all applicable staff on the change in the policy 14-2 DHS that includes notifying facilities as required by the standard. In addition, if applicable, the facility must provide the Auditor with any detainee files where the detainee was transferred as a result of a sexual abuse allegation to confirm the facility is following the updated Sexual Response Plan.

Corrective Action Taken (c)(d): The facility did not provide the Auditor with updated facility policy 14-2 DHS, which doubles as their coordinated response plan, nor did the facility provide documentation that all applicable staff received training on the updated policy. The facility provided the Auditor with a copy of a mental health appointment confirmation, which had no relevance to this standard's requirement. In addition, the facility provided the Auditor with copies of two sexual abuse allegation investigation reports that occurred during the CAP that confirmed that neither of the alleged detainee victims were transferred due to an incident of sexual abuse. Based on the submitted documentation, that did not include updated facility policy 14-2 DHS, which doubles as the facility coordinated response plan, or documentation that applicable staff were trained on the updated plan, the Auditor continues to find the facility does not meet subsections (c) and (d) of the standard.

§115. 76 - Disciplinary sanctions for staff

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

Notes:

(a)(b)(c)(d): Policy 14-2 DHS states, "Employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse. Disciplinary sanctions for violations of CoreCivic policies relating to sexual abuse (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the employee's disciplinary history, and the sanctions imposed for comparable offenses by other employees with similar histories. All terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, to the extent known." The Warden stated that the facility reports staff removals or resignations in lieu of removals, in writing or verbally, for violating sexual abuse policies in potentially criminal cases to EPD and the FOD and that the facility reports, in writing, staff removals or resignations in lieu of removals for violating sexual abuse policies to any relevant licensing bodies. The Warden further stated that staff is subject to disciplinary or adverse action up to and including removal from their position and federal service for substantiated allegations of sexual abuse or for violating facility policies; however, the facility is not in compliance with subsections (a), (b), (c), and (d) of the standard. Policy 14-2 DHS does not contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies," "removal from the Federal service, when there is a substantiated allegation of sexual abuse, or 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," "Each facility shall report all removals or resignations in lieu of removal for violation of Agency or facility sexual abuse polices to appropriate law enforcement agencies unless the action was clearly not criminal," and "Each facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of Agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known." A review of the five investigation files indicated that there were no staff removals or resignations in lieu of removals for violating sexual abuse policies to any relevant licensing bodies.

Does Not Meet (a)(b)(c)(d): The facility is not in compliance with subsections (a), (b), (c), and (d) of the standard. Policy 14-2 DHS does not contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies," "removal from the Federal service, when there is a substantiated allegation of sexual abuse, or 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." In addition, policy 14-2 DHS does not include the verbiage, "Each facility shall report all removals or resignations in lieu of removal for violation of Agency or facility sexual abuse polices to appropriate law enforcement agencies unless the action was clearly not criminal," and "Each facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of Agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known." To become compliant with subsections (a), (b), (c), (d), the facility must update Policy 14-2 DHS to include the required verbiage of the standard and must submit documentation that the updated Policy 14-2 DHS was submitted to the Agency for review and approval. In addition, if applicable, the facility must provide

investigation files that confirm a staff member was disciplined in accordance with the standard 115.76 after an incident of substantiated sexual abuse.

Corrective Action Taken (a)(b)(c)(d): Policy 14-2 DHS states, "Employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse" and "All terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, to the extent known." As the stated verbiage is more stringent than the required verbiage, the Auditor accepts policy 14-2 DHS as written and no longer requires further corrective action. The facility submitted a sexual abuse allegation that occurred during the CAP period that included a staff member; however, the allegation was unfounded; and therefore, the staff member was not subjected to disciplinary action due to the reported incident of sexual abuse. Upon review of all submitted documentation, the Auditor now finds the facility in substantial compliance with subsections (a), (b), (c), and (d) of the standard.

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

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

Notes:

(a)(b)(c): Policy 14-2 DHS states, "If the screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than seventy-two (72) hours after the referral." The two intake officers interviewed confirmed that any detainee disclosure of prior victimization, during intake, requires the detainee be immediately referred to medical. The vulnerability assessment is entered electronically into the Offender Management System (OMS) and if a checkmark is made on the document a referral email is immediately forwarded to medical and mental health for follow up. The HSA and Mental Health Coordinator confirmed when this medical follow-up/referral is initiated, the detainee receives a health evaluation typically the same or next day and no later than two working days from the date of the assessment. When a referral for mental health is initiated, the detainee receives a mental health evaluation no later than 72 hours after the referral. The Mental Health Coordinator further stated any detainee found to have perpetrated sexual assault/abuse would be moved to another facility. The facility submitted a detainee file of a transgender detainee submitted prior to the on-site audit. Although the file confirmed that the detainee had experienced prior sexual abuse, the review of the file could not confirm that the detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate or that the detainee was seen by either practitioner in the timeframes required by the standard.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), or (c) of the standard. The facility submitted a detainee file of a transgender detainee prior to the on-site audit. Although the file confirmed that the detainee had experienced prior sexual abuse, the review of the file could not confirm that the detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate or that the detainee was seen by either practitioner in the timeframes required by the standard. To become compliant, all intake, medical, and mental health staff must be trained in the requirements of policy 14-2 DHS and the standard. In addition, the facility must document said training. The facility must also provide the auditor, if applicable any detainee files, medical files, and/or mental health files of a detainee who experienced prior sexual abuse to confirm the detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate and that the detainee was seen by either practitioner in the timeframes required by the standard.

Corrective Action Taken (a)(b)(c): The facility submitted meeting minutes confirming staff was trained in the requirements of policy 14-2 DHS. In addition, the facility submitted a copy of a MH appt dated 8/3/2022 for a detainee identified as having a risk for sexual victimization during an intake screening dated 8/2/2022. Upon review of the submitted documentation, the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

§115. 86 - Sexual abuse incident reviews

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

Notes:

(a)(b)(c): Policy 14-2 DHS states, "The Facility Administrator will ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be Unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation; The facility shall implement the recommendations for improvement or shall document reasons for not doing so. The 14-2F-DHS Sexual Abuse Incident Review Report shall be forwarded to the PSA Coordinator and the ICE Prevention of Sexual Assault (PSA) Coordinator through the local ICE Field Office." Policy 14-2 DHS further states, "In addition to the Facility Administrator, the incident review team shall include upper-level facility management and the facility SART, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse…Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse." The PSA Compliance Manager verified that the facility considers whether the incident was motivated by race, ethnicity, gender identity, LGBT status, gang affiliation, or by other group dynamics and that the facility conducts an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. The PSA Coordinator further stated, if the facility has not had any reports of sexual abuse during the annual reporting period, then the facility would prepare a negative report and that the results and findings of the annual review will l be provided to the Facility Administrator, FSC PSA Coordinator, and the ICE PSA Coordinator through the local ICE Field Office." The Warden stated that the facility conducts an incident review at the end of every investigation of sexual abuse. He stated that such reviews are completed within 30 days and is documented in the 5-1-IRD system. The PSA Compliance Manager reported that the facility's process for conducting sexual abuse incident reviews includes conducting a sexual abuse incident review at the conclusion of every investigation of sexual abuse, conducting the incident review within 30 days of receiving the investigation results, preparing a written response for every substantiated or unsubstantiated allegation, documenting in the written report whether a change in policy or practice could better prevent or respond to sexual abuse, implementing recommendations for improvement, and forwarding the report and response to the ICE PSA Coordinator. The PSA Compliance Manager further stated this process is achieved through the SART meetings with the corporate office via phone conferencing. The Auditor reviewed five investigative files that occurred during the audit period and confirmed that the four investigative files that indicated the incident occurred at the facility confirmed that the incident reviews contained all required elements of the standard, and were incident completed within 30 days.

The Warden confirmed that the facility has received reports of sexual abuse during the audit period and that if the facility did not receive such report, a negative report would have been completed. The Warden further stated that the facility conducts an annual review of all sexual abuse allegations along with resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts to the ICE FOD and Agency's PSA Coordinator. The Auditor reviewed the annual report submitted with the PAQ and confirmed it was completed by the facility administrator and forwarded to the ICE FOD. The document did not confirm the report was forwarded to the Agency PSA Coordinator.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed the annual report submitted with the PAQ and confirmed it was completed by the facility administrator and forwarded to the ICE FOD. The document did not confirm the report was forwarded to the Agency PSA Coordinator. To become compliant the facility must document that the completed Annual PREA report was forwarded to the Agency PSA Coordinator.

Corrective Action Taken (c): The facility submitted an email to the Agency PSA Coordinator that confirmed the annual report was submitted as required by the standard. Upon review of the submitted documentation, the Auditor now finds the facility is in compliance with subsection (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.

Sabina Kaplan February 9, 2023
Auditor's Signature & Date

Sabina Kaplan February 9, 2023
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) February 3, 2023
Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	4/19/2022	**To:**	4/21/2022
AUDITOR INFORMATION			
Name of auditor:	Cicily Harrington	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-285-
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-579
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	El Paso Field Office
Field Office Director:	Kenneth Genalo
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	5441 Watson Dr., Albuquerque, NM 87106
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Torrance County Detention Facility		
Physical address:	209 County Road, A049		
Mailing address: (if different from above)	P.O. Box 837—Estancia, NM 87106		
Telephone number:	505-384-2711		
Facility type:	IGSA		
PREA Incorporation Date:	5/15/2019		
Facility Leadership			
Name of Officer in Charge:	George Dedos	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-384-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Chief of Security
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-404-

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	Click or tap here to enter text.

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Torrance County Detention Facility (TCDF) was conducted on April 19 – April 21, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Cicily Harrington, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Custom Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) who also provided on-site guidance, and Assistant Program Manager (APM) (b) (6), (b) (7)(C) both are DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR) External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards.

TCDF is a privately owned CoreCivic facility and operates under contact with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult male and female detainees who are pending immigration review or deportation and is in Estancia, NM. The top three nationalities held at TCDF are from Nicaragua, Turkey, and Venezuela. The facility does not house juvenile or family detainees. This was the first PREA audit for TCDC and included a review of the 23-month audit period from May 15, 2019, through January 27, 2022. Prior to the audit, the ERAU Team Lead, Samantha Rittenberg, provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), facility policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation were organized within folders for ease of auditing. The main policy that provides facility direction for PREA is CoreCivic 14-2, Sexual Abuse Prevention and Response. The Auditor reviewed all documentation, policies, and the PAQ and developed a tentative daily schedule for staff and detainee interviews. The Auditor also reviewed the facility's website, www.corecivic.com/facilities/torrance-county-detention-facility.

The entrance briefing was held on April 19, 2022, in the TCDF administrative conference room. The ICE ERAU Team Lead opened the briefing, via telephone, and then turned the meeting over to the Auditor. In attendance were the following:

- (b) (6), (b) (7)(C) Assistant Warden (AW) and Prevention of Sexual Assault (PSA) Compliance Manager, TCDF
- (b) (6), (b) (7)(C) Chief of Unit Management, TCDF
- (b) (6), (b) (7)(C) Grievance Coordinator (GC), TCDF
- (b) (6), (b) (7)(C) Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU
- (b) (6), (b) (7)(C) ICE/ERO/Supervisory Detention and Deportation Officer (SDDO)
- Cicily Harrington, Certified PREA Auditor, Creative Corrections, LLC
- (b) (6), (b) (7)(C) PM/Certified PREA Auditor, Creative Corrections, LLC

The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews. Immediately after the entrance briefing, the Auditor and PM were provided a complete tour of the TCDF by the PSA Compliance Manager, GC and Chief of Unit Management. The facility is comprised of 10 buildings that contain multiple housing units, including five units where detainees are housed separately from both county and U.S. Marshal's inmates. The facility houses adult female and male detainees with low, medium, and high security levels. The average time detainees are held in custody at TCDF is 45 days. In addition to housing ICE adult detainees, the facility also houses federal, state, and municipal inmates; each population type is housed separately. Total facility population capacity is 910 with a total of 162 ICE detainees housed in the facility. On the first day of the audit, the facility ICE population was 111 male detainees. During the audit, the Auditors observed the two detainee housing units, the segregation housing unit, intake/booking area, kitchen, and medical unit where detainees may be held. During the onsite review, the Auditor spoke with staff, contractors, and the ICE detainees regarding the facility's processes and compliance with PREA. The Auditors were advised that volunteers had not entered the facility within the past two years due to the facility's COVID-19 restrictions. The Auditors interviewed a total of 23 staff, no volunteers, and 1 contractor staff. Specialized staff interviewed included the Assistant Field Office Director (AFOD), SDDO, Warden, PSA Compliance Manager, GC, Intake Coordinator/Classification Supervisor, Librarian, Human Resources (HR) Manager, Mail Room Clerk, Training Supervisor, Health Services Administrator (HSA), Mental Health Coordinator, and the facility Investigator. Ten random staff interviewed included seven Detention Officers (DO's), one Captain, and two Sergeants. Contract staff included the Food Services Director.

The Auditor randomly selected 21 detainees to interview. However, one detainee declined to be interviewed and two were quarantined due to the COVID-19 Pandemic. Therefore, the Auditor conducted interviews with 18 detainees, which included 17 who were limited English proficient (LEP) and one random who spoke and understood English. Additionally, the Auditor also randomly selected 12 personnel records, 10 staff training records, and 10 detainee files to review while onsite.

The Auditor observed PREA audit notices, ICE DHS-prescribed Sexual Assault Awareness Information pamphlets, Central New Mexico Rape Crisis Center (RCC) information, and facility zero-tolerance signage posted throughout the facility.

All the housing areas have telephones available to the detainees. Posted by the telephones is the information on DHS Office of Inspector General (OIG) Poster, ICE Detention Reporting and Information Line (DRIL) Poster, and consulate information. Detainee reporting and advocacy services are provided by RCC and this information is also posted near each of the telephone areas in each housing area. The Auditor tested the telephones in multiple housing areas and found them all operational. Additionally, the facility maintains an internal detainee reporting line that immediately notifies the PSA Compliance Manager. The Auditors conducted a test of the internal PREA reporting line, and successfully found the PSA Compliance Manager was immediately notified via a text message. The Auditor was also able to contact the DHS OIG and a RRC hotline representative. In each case, the Auditor informed the representative on the purpose of the call. Both representatives stated their understanding of accepting PREA allegations and/or complaints and each said that all can be made anonymously if requested by the detainee.

Each of the dormitories contained a logbook, which was inspected by the Auditor. All contained unannounced rounds by supervisory staff at random hours throughout each day and night. The entries contained the exact time the round was made and were not posted at regular intervals.

The kitchen is operated by Trinity Food Service and supervised by at least one DO. Detainees are assigned food service duties and the auditors observed staff supervision during the three days onsite. A food service area logbook is maintained, and the Auditor's inspection revealed that unannounced rounds are being made at all hours of the day and not at regular intervals.

(b) (7)(E) pproximately half of these cameras have pan, tilt, and zoom capabilities. The cameras are monitored 24 hours a day, 7 days a week, by DOs in the Master Control Center. The initial surveillance camera system was installed in 2017.

There were nine sexual abuse allegations reported during the audit period. Six cases involved detainee-on-detainee and three cases involved staff-on-detainee. Of the nine cases reported, eight were closed and one case involving a detainee-on-detainee remains open. A review of the closed cases indicated that one case involving a detainee-on-detainee was determined to be substantiated, two cases involving a detainee-on-detainee were determined to be unsubstantiated, one case involving staff-on-detainee was determined to be unsubstantiated, two cases involving a detainee-on-detainee were determined to be unfounded, and two closed cases have no determination noted. Eight cases were submitted to ICE ERO, one case was not referred to ERO, and four cases were not referred to the Joint Intake Center (JIC). One allegation reviewed by the Auditor involved an incident that occurred at another facility and the detainee victim reported the incident to TCDF. The Auditor thoroughly reviewed five investigative files during the on-site audit, which confirmed four out of the five investigations were completed by the facility investigator. Of the five cases reviewed, one detainee-on-detainee case was substantiated, two detainee-on-detainee cases were unsubstantiated, one staff-on-detainee case was unfounded, and one occurred at another facility and had no determination noted. The spreadsheet provided by ICE confirmed all eight closed investigations were completed by facility investigators.

On April 21, 2022, the exit briefing was held in the TCDF administrative conference room. The exit briefing included the following attendees:

- (b) (6), (b) (7)(C) AW and PSA Compliance Manager, TCDF
- (b) (6), (b) (7)(C) Chief of Unit Management, TCDF
- (b) (6), (b) (7)(C) GC, TCDF
- (b) (6), (b) (7)(C) ICE/OPR/ERAU/ICS
- (b) (6), (b) (7)(C) ICE/ERO/SDDO
- Cicily Harrington, Certified PREA Auditor, Creative Corrections, LLC
- (b) (6), (b) (7)(C) PM/Certified PREA Auditor, Creative Corrections, LLC

The Team Lead, via telephone, began the exit briefing by thanking the facility for their hospitality. Following a brief overview of the audit, the meeting was turned over to the Auditor. The Auditor also thanked the facility for their flexible schedules and their cooperation with the audit. The Auditor advised that she would not be able to provide the facility with a definitive audit result until all documentation, onsite notes, and interview notes with staff, volunteers, contractors, and the detainees were reviewed. The Auditor turned the meeting back over to the Team Lead who explained the next steps of the audit process.

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 Not Applicable: 2
§115.14 Juvenile and family detainees
§115.18 Upgrades to facilities and technologies

Number of Standards Met: 28
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.31 Staff training
§115.32 Other training
§115.35 Specialized training: Medical and Mental Health Care
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.66 Protection of detainees from contact with alleged abusers
§115.67 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
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 11
§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
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.53 Detainee access to outside confidential support services
§115.65 Coordinated response
§115.76 Disciplinary sanctions for staff
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

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

(c): Policy 14-2-DHS (Sexual Abuse and Prevention and Response) requires, "zero-tolerance towards all forms of sexual abuse." The policy outlines the facility's approach to accomplish this goal through hiring practices and ensuring employees, contractors, volunteers, and detainees are trained and informed of the zero-tolerance policy regarding sexual abuse and assault, the means to report it, and consequences for violations. The Warden confirmed that this policy was reviewed and approved by the Agency and provided the Auditor with documentation of the policy review by the ICE AFOD. Interviews with random staff and detainees indicated they are aware of the facility's zero-tolerance policy on sexual abuse.

(d): Policy 14-2 DHS states, "The facility shall designate a Prevention of Sexual Assault (PSA) Compliance Manager who shall serve as the facility point-of-contact for the local ICE field office and ICE PSA Coordinator." During his interview, the PSA Compliance Manager verified he is the point of contact for the Agency's PSA Coordinator, and he has sufficient time and authority to oversee efforts for the facility to comply with the facility and Agency zero-tolerance policy.

§115.13 - Detainee supervision and monitoring.

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

(a)(b): Policy 14-2 DHS states, "The CoreCivic Facility Support Center (TCDF) will develop, in coordination with the facility, comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and shall review those guidelines at least annually. Each facility will ensure sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. Whenever necessary, but no less frequently than once each year, for each CoreCivic facility, an annual PREA Staffing Plan Assessment will be completed. The Facility PSA Compliance Manager will complete the 14-2I-DHS Annual PREA Staffing Plan Assessment and forward it to the Facility Administrator for review. Upon completion of the Facility Administrator's review, the 14-2I-DHS Annual PREA Staffing Plan Assessment will be forwarded to the FSC PREA Coordinator. In consultation with the respective FSC Business Unit Vice President/designee, the FSC PSA Coordinator shall assess, determine, and document whether adjustments are needed to: the staffing plan established pursuant to this section; the facility's deployment of video monitoring systems and other monitoring technologies; and the resources the facility has available to commit to ensure adherence to the staffing plan. Changes to staffing, policy/procedure, physical plant, approved capital expenditures, video monitoring and/or technology require the approval of the Business Unit Vice President/designee."

The Auditor observed the three holding rooms located in the intake/classification area are mostly surrounded by glass allowing intake staff to have high visibility to ensure the safety and security of detainees. The Auditor observed two officers on post in the intake area during the onsite audit review who stated that security rounds are conducted every 15 minutes in the intake area. (b) (7)(E) [redacted] The 2 Central Control DOs interviewed indicated that they observe the surveillance monitors 24 hours a day, 7 days a week. They further indicated that at least one person is assigned to the Central Control post throughout the day. Both the Sergeant and DO assigned to restrictive housing stated during their interview that they conduct 30-minute security checks. The Sergeant further stated that 30-minute checks are conducted on all three shifts to ensure safety and security of detainees. The Warden, and PSA Compliance Manager, verified in their interviews that the facility maintains sufficient supervision of detainees to protect against sexual abuse through 30-minute security checks, video monitoring, and comprehensive supervision monitoring. They both stated that comprehensive guidelines are reviewed annually by the AW, Warden, and the corporate office. The Warden and PSA Compliance Manager advised that the comprehensive plan does not incorporate a staff-to-detainee ratio; however, there are specific posts that must remain open and have adequate assignment of staff. The Warden further advised that qualified staff from other CoreCivic facilities may have to assist TCDF due to staffing shortages. The Auditor reviewed the facility's 2021 Supervision Guidelines. In accordance with the facility's guidelines, there is at least one DO assigned to each housing unit on all three shifts to include the night shift. Also, through the Auditor's review of the facility's guidelines, medical staff are onsite 24 hours a day, 7 days a week. In addition, the supervision guidelines reflect that Central Control staff are assigned to their post 24 hours a day, 7 days a week. The Auditor reviewed the Shift Supervisor's Post Orders and verified that each Shift Supervisor ensures adequate levels of detainee supervision through open communications with the Administrative Duty Officers (ADOs) and through keeping track of DO's assigned posts. Also, the Auditor verified through review of the DO Post Orders that security staff ensure adequate supervision by ensuring doors are secure and all detainees are accounted for.

(c): Policy 14-2 DHS states, "In calculating staffing levels and determining the need for video monitoring, the following factors shall be take into consideration: generally accepted detention and correctional practices; any judicial findings of inadequacy; all components of the facility's physical plant; the composition of the detainee population; the prevalence of Substantiated and Unsubstantiated incidents

of sexual abuse; recommendations of sexual abuse incident review reports; and any other relevant factors, including but not limited to the length of time detainees spend in agency custody." The Warden stated he meets with the ADOs and department leaders every Monday to ensure adequate supervision of detainees by taking into account generally accepted detention and correctional practices, any judicial findings of inadequacy, staffing levels, blind spots, video surveillance, composition of the detainee population, prevalence of substantiated and unsubstantiated allegations of sexual abuse and length of time a detainee is housed at TCDF. In fact, the PSA Compliance Manager added that because of the weekly meetings, the facility installed surveillance mirrors under the stairs in the housing units for enhanced supervision of detainees. The PSA Compliance Manager also advised that the facility's leadership team reviews security coverage during staff meetings and after every incident to identify and abate inadequacies.

(d): Policy 14-2 DHS states, "Staff, including supervisors, shall conduct frequent unannounced security inspections rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds shall be documented in the applicable log (e.g., Administrative Duty Officer, post log, shift report, etc.) as "PREA Rounds." This practice shall be implemented on all shifts (to include night, as well as day) and in all areas where detainees are permitted. Employees shall be prohibited from alerting other employees that supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the facility." The Shift Supervisor Post Order states, "In accordance with the ICE contract, for safety, security, and sanitation purposes, an inspection of the detainee housing areas shall be conducted by a supervisor at a minimum of two (2) times per shift. These inspections will be documented, including results, in the unit control logbooks." In interviews with 10 random staff (7 DOs, 1 Captain, 2 Sergeants) it was stated that they conduct unannounced, 30-minute security inspections. The Auditor reviewed 12 logbook entries of security checks. All 12 entries reflected that a PREA security check had been completed at least twice daily. The logbook entries also reflected that the Warden, and other ADOs, visit the housing units daily to conduct PREA security checks.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b)(c)(d): TCDC does not house juvenile and family detainees. A review of the PAQ, a PSA Compliance Manager's memo, and interviews with the Warden, PSA Compliance Manager, and 10 random staff (7 DOs, 1 Captain, 2 Sergeants) verified that the facility does not house juveniles or family detainees.

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

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

Notes:

(b)(c)(d): Policy 14-2 DHS Policy Change Notice (PCN) 04 (Searches) and the Senior Correctional Officer–Transportation Post Order state, "Cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in other exigent circumstances," and "Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances." Policy 14-2 DHS PCN 04 and the Senior Correctional Officer–Transportation Post Order further state, "All cross-gender pat-down searches shall be documented." The PSA Compliance Manager's memorandum, dated 2/23/22, states that the facility has not conducted a cross-gender search of a detainee within the preceding year. In interviews with 10 random staff (7 DOs, 1 Captain, 2 Sergeants) it was reported that they have never witnessed a cross-gender pat search of a detainee. In addition, the facility provided a blank copy of the "Record of Search" form, which would be used to document pat-down searches to confirm there is a practice in place to document a cross-gender pat-down search, should one become necessary.

(e)(f): Policy 14-2 DHS PCN 04 states, "The strip search shall be conducted by employees of the same sex as the inmate/resident being searched except in temporary unforeseen circumstances that require immediate action in order to combat a threat to the security or institutional order of a facility. Any occurrence of such cross-gender strip searches shall be documented in the 5-1 Incident Report administration process using Form 5-1B Notice to Administration (NTA)." Policy 14-2 DHS PCN 01 further states, "Visual inspections (i.e., inspections in which no physical contact takes place during the inspection) of body cavities may be conducted when reasonable suspicion exists that an inmate/resident may have secreted contraband in the rectum and/or vagina, upon approval of the Shift Supervisor. The visual inspection of the body cavity(ies) will be conducted in an area that provides privacy to the inmate/resident. The Shift Supervisor will designate two (2) correctional staff of the same gender as the inmate/resident, to perform the visual inspection. One (1) staff member will conduct the visual inspection while the other staff member witnesses the process. All visual inspections of body cavities must be documented (i.e., post logbook, designated form, etc.) and maintained in accordance with CoreCivic Policy 1-15 Retention of Records. CoreCivic policy 9-5 states, "CoreCivic personnel are not authorized to conduct physical searches of body cavities." On-site health services staff may evaluate the inmate/resident to determine if a life-threatening situation exists that requires further evaluation or treatment. If on-site health services staff recommends further evaluation or treatment, the inmate/resident will be transported to an off-site medical facility for a medical procedure to be conducted. All medical records from the outside medical facility, relating to the evaluation and/or treatment, must be obtained and placed in the inmate/resident's medical record." The Shift Supervisor Post Order states, "ICE detainees will only be strip-searched in accordance with CoreCivic policy 9-5 searches of inmates/residents and various locations." The Senior Correctional Officer-Transportation Post Order states, "ICE detainees will not be strip searched unless there is reasonable suspicion that the detainee is concealing a weapon or contraband. The Shift Supervisor must authorize any strip search based on reasonable suspicion." Interviews with random DOs confirmed staff are aware of the facility's policy for conducting strip or body-cavity searches, and that if performed, shall be approved by a supervisor, and documented on an incident report. During the audit period, no cross-gender strip or body-cavity searches were conducted. This was confirmed through interviews with security supervisors and DOs. The facility does not house juvenile detainees.

(g): Policy 14-2 DHS states, "Detainees shall 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 checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Employees of the opposite gender must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." During the onsite audit review, the Auditor observed a total of three separate shower stalls in the intake area. Although the shower had perforated doors, the intake staff and ADO confirmed that a mobile privacy screen is placed in front of the showers to prevent staff of the opposite-gender from viewing detainees while showering or changing their clothes. On the second day of the audit, the Auditor observed the mobile privacy screen placed in front of the showers while two different detainees showered. During the onsite tour, the Auditor also observed a blind spot in the kitchen near the dishwasher. The Auditor informed the Warden and the AW of the blind spot concern; and at the end of the day, the AW informed the Auditor that a surveillance mirror had already been ordered to abate the issue. On the last day of the Audit, the facility provided the Auditor with photos of the surveillance mirror installed in the kitchen's blind spot along with the purchase and work orders. (b) (7)(E)

(b) (7)(E)

Interviews with 10 random staff (7 DOs, 1 Captain, 2 Sergeants) indicated they announce their presence upon entering a housing unit that houses detainees of the opposite gender by stating "Female on Unit" or "Male on Unit" to ensure detainees' privacy while showering, using the bathroom, and changing clothing. During their interviews, all 18 detainees reported they feel they have privacy to shower, change clothing, or conduct bodily functions without staff of the opposite gender viewing and that most staff of the opposite gender announce themselves prior to entering the housing units. In addition, upon entering the male housing units, the unit officer announced the female Auditor's presence.

(h): TCDC is not designated as a Family Residential Center; therefore, provision (h) is not applicable.

(i): Policy 14-2 DHS states, "The facility shall not search or physically examine a transgender or intersex detainee for the sole purpose of determining the detainee's genital status. If the detainee's genital status is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner." Interviews with 10 random staff (7 DOs, 1 Captain, 2 Sergeants) and the HSA indicated they have not conducted, or been a witness to, a search or physical examination to determine a detainee's gender.

(j): Policy 14-2 DHS states, "In addition to the general training provided to all employees, security staff shall receive training in how to conduct cross-gender pat-down searches, and searches of transgender and intersex detainees, in a manner that is professional, respectful, and the least intrusive possible while being consistent with security needs." Interviews with 10 random staff (7 DOs, 1 Captain, 2 Sergeants) verified that they have received training on how to conduct pat-down searches in a professional, respectful way, and in the least intrusive manner. The Training Coordinator stated that she trains security staff on proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees. The Training Coordinator also confirmed that such training includes how to conduct a pat-down in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and the Auditor reviewed the training curriculum, which met the standard requirement. The Auditor also viewed seven staff training records (five DOs, two ICE staff) and found all seven records noted both initial and annual training on how to conduct pat down searches.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 14-101 (Disability Identification Assessment and Accommodation) states, "Throughout the facility's programs and activities, including at all stages of the reasonable accommodation process, the facility must take appropriate steps to allow for effective communication with detainees with disabilities to afford them an equal opportunity to participate in, and enjoy the benefits of, the facility's programs and activities. Steps to ensure effective communication may include the provision and use of auxiliary aids or services for detainees with vision, hearing, sensory, speech, and manual impairments, as needed. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual detainee, the nature, length, and complexity of the communication involved, and the context in which the communication is taking place. In determining what types of auxiliary aids or services are necessary, the facility shall give primary consideration to the request of the detainee with a disability. Use of other detainees to interpret or facilitate communication with a detainee with a disability may only occur in emergencies. The facility shall provide detainees with disabilities with necessary accommodations in an expeditious manner. In many situations, the facility will be able to immediately grant a detainee's request for an accommodation. Referral to the multidisciplinary team (a healthcare professional and any additional facility staff with requisite knowledge of and/or responsibility for compliance with disability policies and procedures; the team may consist of two or more staff) may be appropriate for detainees who are identified as having a cognitive, intellectual, or developmental disability, including a traumatic brain injury. Facility staff should not require the detainee's participation in the assessment process and should be sensitive to the fact that some detainees in this category may not perceive themselves as having a disability. However, facility staff should provide appropriate assistance to a detainee with a cognitive, intellectual, or developmental disability, even if not explicitly requested (for example, reading and explaining a form to a

detainee with limited cognitive abilities)." Policy 14-2 DHS states, "The facility shall ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse." The Auditor reviewed four detainee files submitted with the PAQ that contained the detainee's booking information, completed Language Preference form, and SAAPI Education Acknowledgement form signed by the detainee; the acknowledgement form indicated that they had received the SAAPI and the facility's orientation, the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, the ICE National Detainee Handbook, and the PREA video. In addition, a Receiving & Discharge Checklist was provided to the Auditor acknowledging the detainee's receipt of the TCDF detainee handbook (only available in English and Spanish), ICE National Detainee Handbook, and facility PREA and DHS-prescribed Sexual Abuse Awareness Information pamphlets. The Auditor reviewed the provided documentation and confirmed based on the booking information that the four detainees were issued the PREA information, including the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Abuse Awareness Information pamphlet, and the facility and ICE National Detainee Handbook. In addition, the Auditor also confirmed that all information, with the exception of the facility detainee handbook, was delivered to all but one detainee in the detainee's preferred language. The facility provided the Auditor with a copy of the DHS-prescribed Sexual Abuse Awareness Information pamphlet in the following languages: English, Spanish, French, Hindi, Punjabi, Chinese, Arabic, Haitian Creole, and Portuguese. In addition, the facility provided a copy of the ICE National Detainee Handbook in English, Spanish, French, Portuguese, Arabic, Hindi, Punjabi, Haitian Creole, Chinese, Turkish, Romanian, Russian, and Vietnamese to the Auditor prior to the Auditor's facility visit. Throughout the onsite tour, the Auditor observed the ICE zero tolerance posters, DHS-prescribed Sexual Abuse Awareness Information pamphlets, consulate posters, and the RCC posters on housing unit bulletin boards in English and Spanish. The Auditor observed the PREA hotline and RCC numbers painted on the walls near the phones in the housing units and posted throughout the facility. The Auditor observed the PREA video playing in the intake holding cells in English and Spanish with closed caption. The Intake Coordinator advised that the PREA video is in English, Spanish, and French, and further stated that the video information is not translated into other languages, but she ensures detainees who speak other languages are provided the DHS-prescribed Sexual Abuse Awareness Information pamphlet and ICE National Detainee Handbook in their preferred language. The Intake Coordinator further stated if she needed additional DHS-prescribed Sexual Abuse Awareness Information pamphlets and ICE National Detainee Handbooks, she would immediately consult the SDDO or any ICE staff who is assigned to the facility. The Auditor also observed that the ICE National Detainee Handbooks are provided in 14 different languages in the detainee tablets located in the housing units. On the second day of the audit, the Auditor was able to observe the initial intake process. The facility received 31 new detainees who were all LEP. Two medical nurses preliminarily screened each detainee by allowing the detainees to read a line of questions in their preferred language. The questions were translated in 12 different languages (English, Spanish, Portuguese, Turkish, Arabic, Chinese, Bangladesh, Haitian-Creole, Uzbek Farsi, Punjabi, Russian, and Sri Lanka) to determine if they needed immediate medical attention. Given the large number of intakes, the Auditor was only able to observe the entire intake process of two detainees. The Auditor observed that classification staff utilized a staff interpreter and the facility's interpretive language line to conduct the two detainees' initial screenings and provided them with a DHS-prescribed Sexual Abuse Awareness Information pamphlet and the ICE National Detainee Handbook in their preferred language. The Auditor observed that medical staff only utilized the facility's interpretive language line to conduct the PREA intake screening and to ensure the privacy of the detainees' medical status.

The interview with the facility investigator and a thorough review of five investigative files confirmed sexual abuse or sexual abuse interviews are conducted through the use of the facility interpretive language line when necessary. The facility investigator confirmed that three of five investigations required the use of the facility's interpretive language line.

During the audit, the Auditor conducted a total of 18 random detainee interviews. Of the 18, there was only one detainee who fluently spoke and understood English; the other 17 detainees spoke Spanish, Portuguese, Turkish, or Arabic. During their interviews with the Auditor, 11 detainees reported when they first arrived at TCDF, they were able to communicate with the facility staff during intake. Five detainees reported that although they were not able to effectively communicate with staff during intake, interpreter services via staff or the language line were provided. Two detainees reported that another detainee provided interpreter services during intake, but that medical provided such services via the interpretive language line. Twelve random detainees stated they needed interpreter and translation services to communicate with facility staff or read written materials in the facility and that facility staff provided the requested interpretation. In addition, all 17 LEP detainees reported they had been seen by medical during the intake process and that medical utilized the language line to conduct their assessment.

The Auditor conducted an interview with 10 random staff (7 DOs, 1 Captain, 2 Sergeants). All 10 random staff stated they have never communicated with a detainee who is deaf or hard of hearing, but that they would provide the detainee with the facility's information on sexual abuse prevention and response through written materials posted throughout the facility. In addition, the random staff stated they have never communicated with a detainee who is blind or has low vision but that they would read written materials to such detainees and provide them with audible video. All random staff reported they have never communicated with a detainee who has intellectual, psychiatric, or speech disabilities, and if they did, they would speak slowly and clearly to the detainee to provide the detainee with the facility's written information on sexual abuse prevention and response. Also, all 10 random staff reported they have communicated with a detainee who is limited in their ability to speak or understand English and that they have used the facility's language line to read TCDF's written materials regarding sexual abuse prevention, intervention, and response, as well as having provided the detainee with the ICE and SAAPI pamphlet in their own language. Likewise, the 10 random staff reported they would not use another detainee, the alleged abuser, a detainee witness, or a detainee who has a significant relationship to the alleged abuser to interpret any incidence of sexual abuse. In addition, the Auditor confirmed during the onsite audit review that should a detainee require a language other than English or Spanish, the tablets in the housing units provide the ICE National Detainee Handbook in the

14 most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). During the interview, the PSA Compliance Manager stated that the facility provides impartial and accurate accommodations such as in-person (staff interpreter) and telephonic (language line) interpretive services to detainees with communication-related disabilities or who are LEP. Also, the PSA Compliance Manager stated that the facility provides written information about sexual abuse to detainees through the facility's detainee handbook and postings located on the housing unit bulletin boards. The PSA Compliance Manager also verified that the facility provides assistive devices such as a teletypewriter (TTY) (located in the Unit Manager's office) and a closed-captioned PREA video for detainees who are deaf or hard of hearing. The PSA Compliance Manager also stated that the PREA video's audio is used for those detainees who are blind or have low vision.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard which requires that the facility ensure that LEP detainees have meaningful access to all aspects of the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The facility provides the detainee with an orientation video during orientation, and on the housing pods, which contains information regarding the facility's efforts to prevent, detect, and respond to sexual abuse; however, the RCC notifications and video is only available in French, English and Spanish. In addition, the facility also provides the RCC contact information through postings on the housing pods and in the TCDF Detainee handbook; however, this information is available only in English and Spanish. Interviews with staff could not confirm that the PREA information available to detainees in the orientation video is accessible to LEP detainees in a manner that they could understand. To become compliant, the facility must develop a practice that would allow LEP detainees who do not speak French, English or Spanish access to the PREA information provided by the facility on the orientation video. In addition, the facility must provide the RCC contact numbers in a manner detainees who do not speak English or Spanish can understand. Once developed, all Intake staff must receive documented training on the new procedures and the facility must present the Auditor with 10 detainee files that are for detainees who speak languages other than English or Spanish to confirm that the detainees are getting the video information and RCC contact numbers in a format they understand.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b): The Auditor reviewed CoreCivic Policy 14-2 DHS that states, "To the extent permitted by law, CoreCivic will decline to hire or promote any individual, and decline to enlist the services of any contractor or volunteer, who may have contact with detainees, who: has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; has been civilly or administratively adjudicated to have engaged in the activity as outlined above. To the extent permitted by law, CoreCivic may decline to hire or promote and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information. All applicants, employees, and contractors who may have direct contact with detainees shall be asked about previous misconduct, as outlined above in written applications or interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees." The HR Manager verified through her interview with the Auditor that the facility acquires a staff member's information of sexual abuse history through written applications for hiring and promoting as well as employee self-evaluations, and if there is anything of question, especially pertaining to sexual abuse which stems from the applicant's background check, the facility would withdraw the applicant from the application process. She stated that staff who have a substantiated finding of sexual misconduct would no longer be employed with the facility. The HR Manager further stated that employees have a continuing affirmative duty to disclose any sexual misconduct. The HR Manager informed the Auditor that contractors and volunteers are prohibited from contact with detainees if they have engaged in sexual activity, have been convicted of engaging or attempting to engage in sexual activity by force, coercion, or without consent, and have been civilly or administratively adjudicated to have engaged in abusive sexual activity. The HR Manager also informed the auditor that she makes an attempt to contact prior institutional employers on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. According to the HR Manager, TCDF has not had any new volunteers to come into the facility for at least the past two years due to the COVID-19 pandemic. The Auditor viewed the HR file record for one volunteer that had contact with detainees prior to the COVID-19 pandemic.

(c): The Auditor reviewed Policy 14-2 DHS that states, "Before hiring new employees who may have contact with detainees, each CoreCivic facility shall require a criminal records background check…CoreCivic shall ensure that criminal background records checks are completed at least every five years for current employees and contractors who may have contact with detainees." The HR Manager reported that potential employees undergo CoreCivic and ICE pre-employment assessments prior to hiring. The Auditor conducted file reviews of eight facility staff (one of which was hired during the audit period) and one ICE employee and found that nine had received an initial facility and/or ICE background investigation. Amongst the staff selected, there was only one file that reflected a promotion; a background was completed during the promotion process. Also, given that the facility recently established an ICE PREA incorporation date of May 15, 2019, all files indicated that the background checks were well under the five-year subsequent check requirement. All nine files reviewed indicated that a Criminal Background check had been completed through ICE Personnel Security Office (PSO).

(d): The Auditor reviewed Policy 14-2 DHS that states, "CoreCivic shall further ensure that a criminal record check is completed before enlisting the services of any contractor who may have contact with detainees." The HR Manager verified that the ICE SDDO is consulted during the background check on all contractors. She stated that a First Advantage Check and eQUIP background investigation are used during the hiring and promotions process. According to the HR Manager, subsequent background checks are

completed every five years by the ICE Contracting Office Representative. The Auditor selected a staff contractor's file for review. The facility SDDO provided the Auditor with documentation confirming that an initial background check had been completed.

(e): Policy 14-2 DHS states, "To the extent permitted by law, CoreCivic may decline to hire or promote and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information." In her interview, the HR Manager verified that material omission regarding sexual abuse or providing false information on an application for employment is grounds for termination or withdrawal of an offer of employment.

(f): The Auditor reviewed Policy 14-2 DHS that states, "Unless prohibited by law, CoreCivic shall provide information on Substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." The HR Manager informed the Auditor, during her interview, that she would cooperate with another facility that requests a reference check on a former TCDF's employee's history of sexual abuse.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): Documentation submitted with the PAQ, and an interview with the facility Warden, determined that TCDC did not design or acquire any new facility, undergo any substantial expansion or modification during the audit period, or install any new, or update its current monitoring system since 2017.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a): Policy 14-2 DHS states, "The investigating entity shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions…The protocol shall be developmentally appropriate for youth where applicable, and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the Department of Justice's Office on Violence Against Women publication, 'A National Protocol for Sexual Assault Medical Forensic' protocols developed after 2011." The Warden confirmed the policy outlining the evidence protocol was reviewed and approved by ICE and provided this documentation to the Auditor.

(b)(c)(d): Policy 14-2 DHSDHS states, "The investigating entity shall attempt to make available to the victim a victim advocate from a rape crisis center. The investigating entity may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services." As indicated in the evidence protocol, victim advocacy services are provided by the following community agency: RCC, 9741 Candaleria Rd NE, Albuquerque, NM 87112. The Memorandum of Understanding (MOU), dated 8/6/19, between the facility and the RCC verifies that the facility will ensure crisis intervention, counseling services, and emotional support services are provided to detainee victims of sexual abuse. If the agency listed above is not available to provide victim advocate services, the investigating entity may make available a qualified staff member from a community-based organization, or a qualified investigating entity staff member, to provide these services. The investigating entity shall offer all victims of sexual abuse and assault access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate and only with the detainee's consent. Such examinations shall be performed by a Sexual Assault Forensic Examination (SAFE) or Sexual Assault Nurse Examiner (SANE) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The investigating entity shall document its efforts to provide SAFE/SANE exams. A review of the evidence protocol confirmed that detainees, with their consent, are transported to the University of New Mexico Hospital (UNMH), for a SAFE/SANE exam with coordination with the Albuquerque SANE Collaborative. The Auditor interviewed a staff member at the UNMH and was able to further confirm that the hospital would provide SAFE/SANE services as required by the standard. The MOU, dated 3/10/22, between the facility and Albuquerque SANE Collaborative verifies that detainee victims of sexual abuse will receive a forensic medical examination by a SANE. The PSA Compliance Manager confirmed that a SAFE or SANE at the local hospital conducts forensic medical examinations on detainee victims and that such examinations are not conducted at the facility. Also, the PSA Compliance Manager confirmed that the RCC provides victims with victim advocacy services during forensic exams and investigatory interviews. The Auditor spoke with a representative of the RRC, who validated the MOU and indicated her agency would provide emotional support, crisis intervention and community referrals and at no cost to the detainee. The Auditor conducted a thorough review of five investigative files and found that victim advocate services were offered to the detainee victims. None of the files reviewed indicated a need for SAFE or SANE services.

(e): Policy 14-2 DHS states, "Investigations conducted by a facility employee for allegations of sexual abuse and assault will be handled in accordance with the Code of Federal Regulations, Title 6, Part 115.21, Evidence Protocol and Forensic Medical Examinations. If the facility is not responsible for investigating such allegations, the facility shall request through the Memorandum of Understanding that the responsible outside agency or entity (i.e., state, or local law enforcement, contracting agency, etc.) comply with these requirements." According to the PSA Compliance Manager's interview, TCDF contacts the Estancia Police Department (EPD) and presents them with all allegations of sexual abuse involving potentially criminal behavior and that EPD follows DHS PREA evidence protocols. The Auditor viewed an MOU dated July 1, 2019, between TCDF and the EPD, and confirmed the EPD agrees "to conduct criminal investigations in accordance with DHS standard 115.21 sections (a) through (d). A review of the MOU further confirmed the MOU automatically renews annually.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(d)(e)(f): The Agency provided a written directive, Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, which states, "When an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (b) (6), (b) (7)(C) 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)." Furthermore, Policy 14-2 DHS states, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators." Policy 14-2 DHS further states, "At this facility, the following law enforcement agencies are notified in accordance with PREA standard 115.22: Estancia Police Department, 1000 Highland Avenue, Estancia NM. When a detainee, of the facility in which an alleged detainee victim is housed, is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director/designee. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director/designee, and to any local government entity or contractor that owns or operates the facility", and "retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years." The Warden confirmed the policy outlining the investigation protocols was reviewed and approved by ICE and provided this documentation to the Auditor. The PSA Compliance Manager stated that upon receiving a report of sexual abuse, the facility investigator immediately makes a referral to the EPD if there is a criminal component, and the facility investigator conducts the administrative investigation. The facility's investigator stated that for each sexual abuse allegation received, the facility leaders (Chief of Security, unit management, mental health, medical, and corporate office) have a meeting within 72 hours to determine if the allegation is criminal in nature and if determined so, EPD is immediately notified. The facility's investigator further stated that if the EPD does not accept the case, EPD then notifies the TCDF. In an interview with the PSA Compliance Manager, it was indicated that if the allegation is not criminal in nature, the facility investigator would conduct an administrative investigation. The Auditor conducted a thorough review of five of the eight allegations reported within the audit period. Of the five reviewed allegations in the investigative files, the Auditor was able to confirm that all five allegations were reported to ICE ERO; however, one case could not confirm that the JIC was notified. In addition, a review of the PREA allegation spreadsheet indicated that eight closed cases were referred to the ICE ERO; however, four were not referred to the JIC by the facility protocol and standard.

Does Not Meet (e)(f): The facility is not in compliance with subsections (e) and (f) of the standard. A review of the PREA allegation spreadsheet and five investigative files indicated that the facility reported the cases to the ICE ERO; however, neglected to report four allegations of sexual abuse, including two against a staff member, to the JIC, ICE OPR or the DHS OIG. To become compliant, the facility must provide documentation, if available, that all incidents of sexual abuse are reported as dictated by the standard. This can be achieved through documentation of any future sexual abuse allegations at the facility. In addition, the PSA Compliance Manager and other involved upper management staff must receive documented training regarding their responsibility to report all incidents of sexual abuse to the appropriate entities.

(c): During the Auditor's review of the TCDC website (www.corecivic.com/facilities/torrance-county-detention-facility), it was determined that the website contains the TCDC investigative protocol. The Auditor also reviewed the ICE website, (https://www.ice.gov/prea), which provided the required Agency protocol.

§115.31 - Staff training.

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

Notes:

(a)(b)(c): Policy 14-2 DHS states, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all new employees and shall also be included in annual refresher/in-service training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards and shall include: The facility's zero-tolerance policies for all forms of sexual abuse. Definitions and examples of prohibited and illegal sexual behavior. The right of detainees and staff to be free from sexual abuse, and from retaliation for reporting 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. How to communicate effectively and

professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; Procedures for reporting knowledge or suspicion of sexual abuse and/or assault." In an interview with the Training Manager, it was reported that TCDF's staff members, who have contact with ICE detainees, receive training on all elements of standard 115.31(a), and that refresher training regarding sexual abuse is provided to staff on an annual basis. The Auditor also reviewed the annual PREA training curriculum and found it includes all required DHS PREA training requirements. Interviews with 10 random staff (7 DOs, 1 Captain, 2 Sergeants) indicated they have received training on sexual abuse prevention and response including annual refresher training.

The Auditor reviewed eight facility staff and one ICE employee's training files. The review of the files confirmed that two staff had completed PREA training within one year of the PREA incorporation date and continued to receive PREA refresher training annually. The additional seven files reviewed reflected new hires within the last 12 months. All seven new hires received PREA training as required by the standard.

§115.32 - Other training.

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

Notes:

(a)(b)(c): Policy 14-2 DHS states, "The facility shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures…The facility shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures." Policy 14-2 DHSDHS further states, "The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees shall be notified of the facility's zero-tolerance policy and informed how to report such incidents" and "Civilians/contractors/volunteers shall be required to confirm, by either electronic or manual signature, their understanding of the received training. Signed documentation will be maintained in the civilian or contractor's file." The Auditor reviewed one contractor and one volunteer file and confirmed they completed PREA training, and that the training completion was documented.

The Training Coordinator verified that the facility has contractors who may have contact with detainees. Although the Training Coordinator stated that all contractors and volunteers who have contact with detainees have been trained on sexual abuse prevention and response, the facility has not allowed any volunteers to enter the facility in approximately two years due to the COVID-19 Pandemic. In addition, the Training Coordinator stated that contractors' and volunteers' training is appropriate based on the level of contact they have with detainees and includes the facility's zero tolerance training.

The Training Coordinator provided the Auditor the training curriculum each volunteer and contractor receives, regardless of the level of detainee contact they have. The training provided addresses the facilities' zero-tolerance, response policies and procedures relating to sexual abuse prevention detection, intervention, and response.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): Policy 14-2 DHS states, "During the intake process, all detainees shall be notified of the facility zero tolerance policy on sexual abuse and assault. Detainees will be provided with information (orally and in writing) about the facility's SAAPI Program. Such information shall include, at a minimum: The facility's zero tolerance policy for all forms of sexual abuse or assault; Prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; Explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS/Office of Inspector General (OIG) and the ICE/Office of Professional Responsibility (OPR) investigation processes; Information about self-protection and indicators of sexual abuse and assault; Prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceeding and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." During the on-site audit the Auditor observed the entire intake/classification process of two detainees in which the intake staff informed the detainees of the facility's zero tolerance policy for all forms of sexual abuse. Also, the Auditor observed the PREA video playing in English and Spanish with closed captioning. The video addresses the following topics: 1) prevention and intervention strategies; 2) definitions and examples of detainee-on-detainee sexual abuse and coercive sexual activity; 3) reporting methods; 4) self-protection and indicators of sexual abuse; 5) retaliation; and 6) detainees' right to be free from sexual abuse." Policy 14-2 DHS further states, "The facility shall post on all housing unit bulletin boards the following notices: The DHS-prescribed sexual abuse and assault awareness notice, the name of the facility PSA Compliance Manager, and information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available). If no such local organizations exist, the facility shall make available the same information about national organizations. The facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities" and "the facility shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information pamphlet." In addition, Policy 14-2 DHS states, "The facility shall maintain documentation of detainee participation in educational sessions pertaining to sexual abuse." In an interview, the Intake Coordinator stated that the detainee orientation program on sexual abuse prevention consists of the PREA video, DHS-prescribed Sexual Assault Awareness Information pamphlet, distribution of the ICE National Detainee Handbook, and facility detainee handbooks. According to the Intake Coordinator, the orientation program includes the following: TCDF's zero tolerance

policy, prevention and intervention strategies, definitions, and examples of sexual abuse (both detainee and staff), multiple ways to report sexual abuse (any staff member, DHS OIG, self-protection methods, indicators of sexual abuse, prohibition against retaliation, and the right to treatment and counseling for detainee victims). The Intake Coordinator further advised that the PREA video is in English, Spanish, and French, and that she ensures detainees who speak other languages are provided the SAAPI pamphlet and ICE National Detainee Handbook in their preferred language. The Intake Coordinator stated that the orientation program on sexual abuse is accessible to detainees who are deaf or hard of hearing through written materials such as the facility detainee handbook, ICE National Detainee handbook, the DHS-prescribed Sexual Assault Awareness Information pamphlet, and a closed captioned PREA video. Also, the Intake Coordinator reported that the orientation program on sexual abuse is available to detainees who are limited in their ability to speak or understand English through the facility's language line, translated materials (TCDF handbook, ICE Detainee Handbook, SAAPI pamphlet), and staff interpreters. In addition, the Intake Coordinator stated that the orientation program on sexual abuse is accessible to detainees who are blind or who have low vision through audio materials available (video) and staff available to read to detainees. The Intake Coordinator also stated that the orientation program on sexual abuse is available to detainees who have intellectual, psychiatric, or speech disabilities; intake staff would read the orientation video transcript and DHS-prescribed Sexual Assault Awareness Information by speaking slowly and clearly and referring the detainees to mental health staff for assistance. According to the Intake Coordinator, the facility's orientation program on sexual abuse is accessible to detainees who have limited reading skills through audible videos and staff reading the information to them. The Auditor also observed that the ICE National Detainee Handbooks are provided in 14 different languages in the detainee tablets located in the housing units. The Warden stated in his interview that the facility has never been unable to provide an accommodation requested by a detainee with a disability. The Auditor reviewed a copy of the video script provided with the PAQ and confirmed it contained all elements required in subsection (a) of the standard.

The Auditor reviewed four detainee files submitted with the PAQ that contained the detainees' booking information, completed Language Preference forms, and SAAPI Education Acknowledgement forms, signed by the detainee indicating that they had received the facility's orientation, the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, the ICE National Detainee Handbook, and viewed the PREA video. In addition, a Receiving & Discharge Checklist was provided to the Auditor acknowledging the detainees' receipt of the TCDF detainee handbook, ICE National Detainee Handbook, the facility PREA and DHS-prescribed Sexual Assault Awareness Information pamphlets. The Auditor reviewed the provided four detainee files and confirmed based on the booking information that detainees were received at TCDC on February 5, 2022; January 20, 2022; August 4, 2021; and September 30, 2021, and each detainee completed orientation and was issued the PREA information, including the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, and the facility and ICE National Detainee Handbook on February 8, 2022; January 22, 2022; August 4, 2022; and October 4, 2021, respectively. The signed acknowledgement also indicated that all detainees viewed the orientation PREA video; however, the video is not offered in two of the detainee's preferred language, nor according to the Intake Coordinator, was it translated to the detainees. In addition, the documentation provided indicated that the fourth detainee did not receive the written PREA information in his preferred language.

Seventeen detainees confirmed when they first arrived at TCDF, they remember receiving information about sexual abuse such as how to stay safe or report an incident of sexual abuse through a staff interpreter, facility detainee handbook in their own language, the SAAPI pamphlet, or hotline information on posters. Three detainees who spoke either Arabic, Portuguese, or Turkish reported that the sexual abuse information was not provided to them in their language and the Auditor confirmed through detainee file review. The Auditor observed the RCC pamphlets posted throughout the housing units and in the intake/classification area in English and Spanish. The Auditor observed the DHS-prescribed sexual assault awareness notices, the name of the PSA Compliance Manager, OIG, PREA hotline, and the RCC posters located on the bulletin boards in the housing units, kitchen, and intake areas.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. Documentation provided with the PAQ confirmed that the orientation process is not completed during the intake process as required by subsection (a) of the standard. The Auditor reviewed the provided documentation and confirmed, based on the booking information, three out of four detainees did not complete orientation or receive the PREA information, including the CoreCivic zero tolerance pamphlet, the ICE DHS-prescribed Sexual Assault Awareness Information pamphlet, and the facility and ICE National Detainee Handbook during the initial intake. Per the Intake Coordinator, the detainee orientation program on sexual abuse prevention consists of the PREA video, SAAPI pamphlet, and distribution of the ICE and facility detainee handbooks. The Intake Coordinator further stated that the orientation video is played in English, Spanish, or French and if a detainee's preferred language is something other than provided by the video, then the detainee would not get the information provided during the video presentation; and therefore, the facility is not compliant with subsection (b) of the standard. To become compliant, the facility must develop a practice that ensures that the detainee orientation is offered and completed during intake. In addition, the facility must have the video script translated and provided to detainees who do not speak English, Spanish, or French at intake. The facility must train all intake staff on the new practice and document such training. In addition, the facility must provide the Auditor with 10 detainee intake files consisting of different languages and different days, to confirm that the orientation is offered and completed during the intake process and that the video is understood by detainees who speak other than English, Spanish, and/or French.

§115.34 - Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy 14-2 DHS states, "The facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training

covers, 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. Documentation confirming that investigators have completed the required specialized training in conducting sexual abuse investigations shall be maintained in accordance with CoreCivic Policies 1-15 Record Retention and 4-2 Maintenance of Training Records." The Agency policy 11062.2 states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement.

Prior to the Auditor's visit of the facility, the facility provided the Auditor with a copy of the facility investigator's training certificate confirming completion of the five-hour PREA Specialized Investigations course provided by the Moss Group, Inc. and through the PREA Resource Center's training portal. The facility also provided a copy of the Facility Investigator Onboarding certificate from CoreCivic confirming the facility investigator's completion of the training. The Auditor reviewed the PREA allegation spreadsheet and noted three facility investigators listed as assigned to conduct investigation; however, the facility only provided documentation that confirmed compliance for one.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of the PREA allegation spreadsheet confirms that the facility utilized three facility investigators to complete sexual abuse allegation investigations during the audit period; however, the facility only provided the Auditor with documentation that one facility investigator was trained. To become compliant, the facility must provide documentation that all staff assigned to conduct facility investigations have been trained in accordance with subsection (a) of the standard. In addition, the facility must provide copies of all sexual abuse investigations that occur during the CAP period to confirm the staff investigating the allegation has received the required training.

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

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

Notes:

(a)(b): The facility's Health Services are provided by CoreCivic, and not ICE Health Services Corps (IHSC); therefore, subsections (a) and (b) are not applicable.

(c): Policy 14-2 DHS states, "In addition to the general training provided to all employees, all full and part-time Qualified Health Care Professionals and Qualified Mental Health Professionals, who work in the facility, shall receive specialized medical training as outlined below: How to detect and assess signs of sexual abuse; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to victims of sexual abuse; How and to whom to report allegations of sexual abuse; and How to preserve physical evidence of sexual abuse." The Warden confirmed the policy outlining medical staff training was reviewed and approved by ICE and provided this documentation to the Auditor. The Training Coordinator stated that specialized training is provided to full and part-time medical and mental health practitioners. According to the Training Coordinator, the specialized training includes how to detect and assess signs of sexual abuse, how to respond effectively and professionally to victims, how and to whom to report allegations or suspicions, how to preserve evidence, and how to conduct forensic medical examinations. The Auditor interviewed the HSA who confirmed specialized training for both Medical and Mental Health staff at TCDF confirmed provided annually and the Auditor reviewed five medical employee training records to confirm compliance.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(c)(d): Policy 14-2 DHS states, "All detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly." Policy 14-2 DHS further states, "The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: 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, and the detainee's own concerns about his or her physical safety. The initial screening shall 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 the facility, in assessing detainees for risk of being sexually abusive." The PSA Compliance Manager verified that detainees are kept separate from the general population during the initial classification process. The Intake Coordinator stated that if a detainee is identified as an individual who is at high risk of sexual victimization or a potential sexual abuse victim, the facility will ensure appropriate housing by placing the detainee on protective

custody status away from potential harm and general population. The one detainee interviewed that fluently spoke English stated he remembered spending time in intake prior to being assigned to a housing unit but was unsure as to how long he stayed in intake.

(b): Policy 14-2 DHS states, "The initial classification process and initial housing assignment should be completed within twelve (12) hours of admission to the facility." The Supervisor Post Order states, "at this facility, the shift supervisor's duties regarding intake/release/transfer procedure ensure detainees are not in holding cells for more than 12 hours." However, Policy 14-2 DHS further states, "Upon arrival at a facility, transgender/intersex detainees shall be temporarily housed in a location away from the general population (to include a medical unit or protective custody unit) for no more than seventy-two (72) hours (excluding weekends, holidays, and exigent circumstances) until classification, housing, and other needs can be assessed." The Intake Coordinator stated that initial classification is conducted within 12 hours of admission to facility and prior to assigning detainees to a housing unit. Prior to the Auditor's visit of the facility, the facility provided the Auditor with the PAQ and a completed ICE Initial Screening Tool, which contained all required elements of the standard. According to the Intake Coordinator's interview, staff use the information from the ICE Initial Screening Tool and the Booking Questions form to assess the detainee's risk for sexual victimization or abusiveness, and to make housing and other classification decisions. However, the Auditor reviewed four detainee files submitted with the PAQ that contained the detainees' booking information and the TCDC Receiving and Discharge Checklist. A review of the information provided indicated that one detainee was received at TCDC on February 5, 2022, one detainee was received on January 20, 2022, one detainee was received on August 4, 2021, and one detainee was received on September 30, 2021. The Auditor further confirmed that the first detainee received his initial housing assignment on February 8, 2022; the second detainee received his initial housing assignment on January 22, 2022; the third detainee received his initial housing assignment on August 4, 2021; and the fourth detainee received his initial assignment on October 4, 2021. The Auditor further confirmed that the detainee who arrived on September 30, 2021, and was not assigned initial housing until October 4, 2021, self-identified as transgender. All detainees were listed as Reception Admission, Initial confirming that they had yet to be classified and assigned initial housing. In addition to the documentation submitted with the PAQ, the Auditor conducted 10 detainee file reviews while at the facility; those 10 indicated that the detainee had received an initial screening within 12 hours.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. The Auditor reviewed a total of four completed initial screenings conducted by intake staff at TCDF and confirmed that three screenings reflected completion well past the standard's requirement. The Auditor further confirmed that the detainee who arrived on September 30, 2021, and was not assigned initial housing until October 4, 2021, self-identified as transgender. In addition, Policy 14-2 DHS allows for staff to hold transgenders for up to 72 hours to complete the initial classification process and determine initial housing. To become compliant, the facility must develop a practice that requires the facility complete initial classification and initial housing assignments within 12 hours for all detainees, including transgender detainees, as required by the standard. In addition, the facility must train all applicable staff on the new practice and document such training. The facility must provide the Auditor with 10 detainee files consisting of 10 different days verifying that the detainee's initial intake and housing assignment was completed within in 12 hours. If applicable, the facility must also provide the Auditor with any detainee files that included a transgender detainee to confirm that the transgender detainee's initial classification and housing in assignment was completed within 12 hours as required by the standard.

(e): Policy 14-2 DHS states, "The facility shall 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." The Intake Coordinator stated that a detainee's risk of victimization or abusiveness is reassessed between 60 and 90 days from the date of their 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. During the 10 detainee file reviews, 2 of the 10 detainees' files were for detainees housed at TCDF for more than 90 days and staff did not perform a reassessment of sexual victimization within the standard requirement of 60-90 days. One detainee's reassessment occurred at day 94 and the second detainee's reassessment occurred at day 103. In addition, a review of five investigative files could not confirm that the facility completed a reassessment following an incident of sexual abuse.

Does Not Meet (e): Although the facility conducted a reassessment of two detainees who had been in the facility past 90 days, the facility did not conduct the reassessments within 60-90 days. In addition, a review of five investigation files could not confirm that the facility conducted a reassessment following an incident of sexual abuse. To confirm compliance, the facility must provide the Auditor, if applicable, with copies of 10 detainee reassessments that occurred with 60-90 days from the date of their initial assessment that occurred during the CAP period. In addition, the facility must provide the Auditor with all sexual abuse allegation investigations that occur during the CAP period to confirm that reassessments are being conducted following an incident of sexual abuse. The facility must also train all applicable staff on the standard's requirements to conduct risk reassessments of detainees within 60-90 days and after an incident of sexual abuse and provide documentation confirming that said staff have received such training**.**
(f): Policy 14-2 DHS states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to items listed above in section." A review of policy 14-2 DHS confirms the "items listed above" include questions asked pursuant to paragraphs (c)(1) (c)(7), (c)(8), (c)(9) of the standard. According to the PSA Compliance Manager's interview, detainees are not disciplined for refusing to answer or for not disclosing information regarding them having the following: 1) a mental, physical, or developmental disability; 2) identifies as lesbian, gay, bisexual, transgender, intersex, or gender nonconforming; 3) self-identifies as having previously experienced sexual victimization; or 4) expresses concerns of physical and sexual safety. According to the Intake Coordinator's interview, detainees are not disciplined for refusing to answer, or for not disclosing complete information in response to mental, physical, or developmental disability, the detainee's self-identification as gay,

lesbian, bisexual, transgender, intersex, or gender nonconforming, the detainee's self-claim of having been previously sexually victimized, and the detainee's expressive concerns about his physical safety.

(g): Policy 14-2 DHS states, "The facility shall 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 detainee dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees. Appropriate controls shall be implemented within the facility regarding the dissemination of responses to questions asked pursuant to screening for risk of victimization and abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees to the detainee's detriment." During their interviews, the PSA Compliance Manager, and the Intake Coordinator, stated that TCDF ensures that only staff with a need-to-know basis is informed about information learned during the classification process through private interviews and acquiring limited access to detainees' physical and electronic files.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Policy 14-2 DHS states, "The facility shall use the information from the 14-2B-DHS Sexual Abuse Screening Tool conducted at initial screening in the consideration of housing recreation, work program and other activities." The Intake Coordinator stated that intake staff make individualized assessments for housing and classification decisions. In an interview, the Classification Supervisor indicated assignments are made for work and housing based on each individual detainee's risk assessment. The Auditor reviewed 10 detainee detention files, in which the DHS Sexual Abuse Screening Tool is kept. The files demonstrated initial risk assessments were conducted on each detainee to determine initial housing assignments; however, the files did not confirm that the information from the DHS Sexual Abuse Screening Tool is considered when determining recreation and other activities, and voluntary work.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41 when determining initial housing, recreation and other activities, or voluntary work assignments. A review of 10 detainee files could not confirm that this information is considered when determining recreation and other activities, or voluntary work assignments. To become compliant, the Initial DHS Sexual Abuse Screening Tool needs to be shared with staff determining recreation, volunteer programming and other activities so that the detainee's risk of sexual abuse can be taken into account. In addition, all Intake and other applicable staff should be trained in the proper use of the Initial ICE Screening Tool when determining the elements of the standard. The facility must also provide 10 detainee files that document that the information from the risk screening is utilized when determining initial housing, recreation, and other activities

(b)(c): Policy 14-2 DHS states, "The facility should not base housing and program placement decisions for 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 shall always be taken into consideration. The facility shall make individualized case-by-case determinations about how to ensure the safety of each detainee." Policy 14-2 Policy 14-2 DHS further states, "Upon arrival at a facility, transgender/intersex detainees shall be temporarily housed in a location away from the general population (to include a medical unit or protective custody unit) for no more than seventy-two (72) hours (excluding weekends, holidays, and exigent circumstances) until classification, housing, and other needs can be assessed." The Intake Coordinator stated that the facility conducts risk assessments and makes housing determinations for transgender or intersex detainees taking into account the detainee's gender self-identification and the detainee's self-assessment of safety needs. The Intake Coordinator further stated the facility assesses the effects of placement on the detainee's health and safety and that the Intake staff would immediately consult with a medical or mental health professional on assessment so that they can make a decision that is consistent with the safety and security considerations of the facility. The Intake Coordinator further indicated that the facility will reassesses the decision at least twice a year. The Auditor reviewed one transgender detainee file submitted with the PAQ and confirmed the transgender detainee was released prior to the required reassessment date; however, a review of the file could not confirm the transgender detainee's housing was determined following consultation with a medical or mental health professional. In an interview with the Intake Coordinator, and random staff, it was indicated that transgender and intersex detainees are given the opportunity to shower separately from other detainees at intake/processing, when operationally feasible.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. The Auditor reviewed the submitted detainee file of a transgender detainee and could not confirm that the facility consulted a medical or mental health professional as soon as practicable regarding the transgender detainee's initial housing assessment. To become compliant, the facility must train all intake, medical, and mental health staff regarding the requirement to consult a medical or mental health professional as soon as practicable regarding the transgender detainee's initial housing assessment. In addition, if applicable, the facility must submit any transgender detainee's detention files, medical files, and mental health files to confirm compliance with subsection (b) of the standard.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c)(e): Policy 14-2 DHS states, "Detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director to determine if ICE can provide 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, and such an assignment shall not ordinarily exceed a period of thirty (30) days." The Auditor confirmed the facility's protective custody procedures were developed in consultation with the ICE Enforcement and Removal Operations Field Office Director having jurisdiction at TCDF. Policy 14-2 DHS further states, "Staff shall document detailing reasons for placement of an individual in Administrative Segregation on the basis of a vulnerability to sexual abuse and assault" and "facilities shall notify the appropriate ICE Field Office Director no later than seventy-two (72) hours after the initial placement into segregation, whenever a detainee has been placed in segregation on the basis of a vulnerability to sexual abuse or assault." Policy 14-2 DHS also states, "Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible." The PSA Compliance Manager's memorandum, dated 2/21/22, states that the facility has not placed a detainee into protective custody within the past 12 months, and should the instance occur, the Warden or designee would provide an email notification to the AFOD and SDDO immediately upon the detainee being placed in protective custody. During the onsite visit, the Sergeant and Librarian stated that detainees in protective custody may participate in library services by submitting a request through the tablet. They also reported that detainees receive visitation commensurate with that of the general population. In his interview, the Warden indicated administrative segregation is the last resort for housing detainees who are vulnerable to sexual abuse and that vulnerable detainees may be placed in another housing unit. The Warden advised that the time limit of keeping detainees in protective custody due to such vulnerability depends upon the situation but would not exceed 30 days.

(d): Policy 14-2 DHS states, "A supervisory staff member shall conduct a review within seventy-two (72) hours of the detainee's placement in segregation to determine whether segregation is still warranted; and a supervisory staff member shall conduct, at a minimum, an identical review 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." The Warden confirmed that any placement of a vulnerable detainee in segregation would require the scheduled reviews as stipulated in policy.

§115.51 - Detainee reporting.

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

Notes:

(a)(b)(c): Policy 14-2 DHS states, "Detainees shall be encouraged to immediately report pressure, threats, or incidents of sexual abuse and assault, as well as possible retaliation by other detainees or employees for reporting sexual abuse and staff neglect, or violation of responsibilities that may have contributed to such incidents. The facility shall provide instructions on how detainees may contact their consular official, the DHS Office of the Inspector General, and the ICE Hotline. Reporting will be confidential, and if desired, anonymous. Detainees who are victims of sexual abuse have the option to privately report an incident to a designated employee other than an immediate point-of-contact line officer by directly reporting the allegation to the US Department of Homeland Security (DHS) Office of the Inspector General (OIG) complaint hotline toll-free telephone number at 1-800-323-8603 (this number also has an option to report outside of ICE)." The Auditor observed during the onsite tour that the phone number and pertinent information are securely posted inside each housing unit for 24/7 access. Policy 14-2 DHS further states, "Detainees shall have at least one way to report sexual abuse to a public or private entity or office that is not part of CoreCivic, and that is able to receive and immediately forward detainee reports of sexual abuse and assault to facility officials, allowing the detainee to remain anonymous upon request." The Auditor tested the available CoreCivic hotline. Although a personal identification number is needed to access the hotline, the Auditor verified through the notification receipt that the individual detainee identification information is not provided and does not impede upon the detainee's ability to confidentially and anonymously report. The Auditor observed posters on the housing unit bulletin boards providing instructions on how detainees may contact their consular official, DHS OIG, and the RCC. The Auditor also observed roll away phones in the medical area and restrictive housing that allow for detainees to confidentially and anonymously report sexual abuse and PREA reporting phone numbers are available on each of the roll away units. Policy 14-2 DHS further states, "Employees must take all allegations of sexual abuse seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports. All reports of sexual abuse will be reported to the Facility Investigator. Employees having contact with the alleged victim should behave in a manner that is sensitive, supportive, and non-judgmental." During the interview, the PSA Compliance Manager verified that detainees may report an incident of sexual abuse to any facility staff, consular official, the DHS OIG, or a family member. Also, the PSA Compliance Manager advised that detainees may privately report sexual abuse in writing, verbally, anonymously, or to a third party. In addition, he stated the facility previously received sexual abuse allegations through the Unit Manager, the grievance system, and the ICE Compliance Officer. Random staff interviewed reported that a detainee may report sexual abuse to someone who does not work at the facility. Random staff also stated they would accept sexual abuse reports that are made verbally, in writing, anonymously, and from a third party and promptly report. The detainee that fluently spoke English stated that he received additional information about sexual abuse through the detainee handbook after the intake process. He stated that the information was provided in his language and that he can report sexual abuse verbally and in writing. The detainee also stated that he is aware that he can anonymously report sexual abuse. LEP detainees also confirmed receipt of detainee handbooks at intake in their language and were aware they can report sexual abuse verbally and in writing.

Recommendation (b): The Auditor recommends that the facility update Policy 14-2 DHS to include the verbiage allowing detainees to report an incident of sexual abuse to a public or private entity that is not part of the Agency, specifically ICE.

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

(a)(b)(c)(d)(e)(f): Policy 14-2 DHS states, "Detainees will be permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. To prepare a grievance a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representative. The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility shall issue a decision on the grievance within five (5) days of receipt and shall respond to an appeal of the grievance decision within thirty (30) days. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process." The Grievance Coordinator confirmed through her interview that the facility did not receive any grievances of sexual abuse through the grievance system within the audit period. Random staff interviewed stated that they would accept a sexual abuse report made through the grievance system and that they would expedite a detainee's request for assistance. The Auditor submitted a test grievance through the detainee tablet and confirmed that the PSA Compliance Manager, Warden, and ADO immediately received an email notification confirming receipt. The Auditor reviewed five investigative files, and none of the allegations were reported through the grievance system.

§115.53 - Detainee access to outside confidential support services.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c): Policy 14-2 DHS states, "CoreCivic shall maintain, or attempt to enter into, Memorandums of Understanding (MOU) or other agreements with community service providers or, if local providers are not available, with organizations that provide legal advocacy and confidential emotional support for immigrant victims of crimes. Each facility shall establish, in writing, procedures to include outside agencies in the facility sexual abuse prevention and intervention protocols, if such resources are available." The Auditor reviewed the Policy 14-2 DHS and confirmed that RCC is included in the policy as required by subsection (b) of the standard. The MOU, dated 8/6/19, between the facility and the RCC verifies that the facility will ensure crisis intervention, counseling services, and emotional support services are provided to detainee victims of sexual abuse. A review of the MOU also confirmed that RCC will ensure crisis intervention, counseling services, and emotional support services are provided to detainee victims of sexual abuse and that MOU will remain into effect unless either party submits in writing a request to end the agreement. The Auditor observed the RCC posters posted on the housing unit bulletin boards. The RCC posters include their mailing address and the toll-free hotline number. In addition, the Auditor reviewed the TCDF Detainee handbook and confirmed the information is available in English and Spanish. The PSA Compliance Manager reported that TCDF informs the detainees about RCC through posters and the facility detainee handbook. The detainee that fluently spoke English stated he remembers seeing or hearing information about organizations that can provide support services for sexual abuse victims.

Recommendation (b): The Auditor recommends that information regarding RCC is made available to detainees who are not English or Spanish proficient.

(d): Policy 14-2 DHS states, "The facility shall require that agencies providing confidential support services inform detainees, prior to rendering services, of the extent to which communications shall be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." Prior to the Auditor submitting the test call to the RCC, the telephonic automation informed the Auditor that the call may be monitored; however, the telephonic communication, facility posting, or the TCDF Detainee handbook advises the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws as required by subsection (d) of the standard.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. Prior to the Auditor submitting the test call to the RCC, the telephonic automation informed the Auditor that the call may be monitored, however, the telephonic communication, facility posting, or the TCDF Detainee handbook advises the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws as required by subsection (d) of the standard. To become compliant, the facility must advise the detainee the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. The facility should also ensure this advisement process accounts for detainees that speak a language other than English and Spanish.

§115.54 - Third-party reporting.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

Policy 14-2 DHS states, "Each facility shall establish a method to receive third-party reports of sexual abuse and shall post this information on the facility PREA link found on the CoreCivic website." The Auditor noted third-party reporting information, in Spanish and English, located in the TCDF visiting area. A review of both the ICE web page https://www.ice.gov and CoreCivic web page https://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea confirmed both web pages provide a means for the public to report incidents of sexual abuse/harassment on behalf of any detainee. In interviews with 18 detainees, the majority were aware that a third-party, such as family members and friends, could report an incident of sexual abuse on their behalf.

§115.61 - Staff reporting duties.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): Policy 14-2 DHS states, "All employees are required to immediately report: any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility in accordance with this policy, whether or not the area is under CoreCivic's management authority; retaliation against detainees or employees who have reported such an incident and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation." Policy 14-2 DHS further states, "Apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, and as specified in this policy, to make treatment, investigation, and other security and management decisions." Policy 14-2 DHS also states, "Reports of Sexual Abuse may also be reported to the CoreCivic Ethics Hotline at www.CoreCivicethicspoint.com." The Warden confirmed that this policy was reviewed and approved by the Agency and provided the Auditor with documentation of the policy review by the ICE AFOD. The interviews with each of the random staff confirmed their knowledge of their reporting requirements of the standard and the facility policy. Each staff person was also aware of their right to go outside the chain of command, through the CoreCivic ethics reporting telephone line, to report sexual abuse if necessary. They also confirmed that apart from reporting to a designated supervisor or official, they are not to reveal any information related to a sexual abuse allegation to anyone.

(d): Policy 14-2 DHS states "If the alleged victim is under the age of eighteen (18) or considered a vulnerable adult under a state or local vulnerable person's statute, the allegation shall be reported to the designated state or local services agency under applicable mandatory reporting laws." There are no juveniles housed at TCDF. The interview with the Warden confirmed, if the facility encountered an incident of sexual abuse involving a vulnerable adult, CoreCivic's counsel's office would be contacted to determine reporting obligations under the reporting laws of New Mexico.

§115.62 - Protection duties.

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

Notes:

Policy 14-2 DHS states, "When it is learned that a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee." During interviews with the Warden and line supervisors, it was indicated that a detainee identified as a substantial risk of imminent sexual abuse would likely be moved to the medical unit to eliminate the threat. Transfer from the facility would be considered after the situation was evaluated. The Auditor's review of the five investigative files confirmed the detainee was immediately separated from the alleged abuser.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d): Policy 14-2 DHS states, "The Facility Administrator of the facility that received the allegation shall contact the Facility Administrator or appropriate headquarters office of the facility where the alleged abuse took place as soon as possible, but no later than seventy-two (72) hours after receiving the allegation. Notification shall be made to the ICE Field Office Director/designee. The facility shall document that it has provided such notification through the 5-1B Notice to Administration." The Warden and PSA Compliance Manager stated if the facility received an allegation of sexual abuse from a detainee reporting sexual victimization while at another facility, the facility would immediately notify the ICE Field Office or the administrator of the facility where the alleged abuse occurred. The Warden and PSA Compliance Manager verified that this notification would be no later than 72 hours. They also stated if the facility received a report from another facility that a detainee had been sexually abused, the facility would immediately notify the qualified facility investigator to begin the investigation into the alleged incident. The Auditor conducted five investigative file reviews. One of the files indicated that a detainee had reported to the TCDF intake staff that he was sexually assaulted in another facility. The Auditor reviewed and verified that upon receiving such report, TCDF's Warden notified the Facility Administrator where the incident allegedly occurred and completed the 5-1B Notice to Administration as required by policy. The Warden also notified the ICE SDDO. The Auditor's interview with the SDDO confirmed that she made the required notification to the appropriate FOD as required by the standard.

§115.64 - Responder duties.

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

Notes:

(a): Policy 14-2 DHS states, "Any employee who discovers or learns of sexual abuse, or an allegation of sexual abuse, shall ensure that the following actions are accomplished: the alleged victim is kept safe, has no contact with the alleged perpetrator and is immediately escorted to the Health Services Department; and the Health Services Department is responsible for medical stabilization and assessment of the victim until transported to an outside medical provider, if medically indicated, for collection of evidence and any necessary medical treatment. CoreCivic will request, in writing, that the examination be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE). If a SAFE or SANE provider is not available, the examination may be performed by other qualified medical practitioners. If the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall, to the best of their ability, ensure that the victim does not wash, shower, remove clothing without medical supervision, use the restroom facilities, eat, drink or brush his/her teeth. In order to preserve any evidence, the alleged perpetrator should not be allowed to wash, shower, brush his/her teeth, use the restroom facilities, change clothes, or eat or drink while secured in segregation in a single cell (if available). The highest-ranking authority on-site is immediately notified and will further ensure to protect the safety of the victim and the integrity of the crime scene and any investigation." The random security staff interviewees detailed their responsibilities when responding to any allegation of sexual abuse, as outlined in the policy, and required by

the standard. The five sexual abuse allegations reviewed by the Auditor confirmed that the first responder followed the requirements of policy 14-2-DHS.

(b): Policy 14-2 DHS states, "If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." The Auditor interviewed four non-security staff and each confirmed, if an incident of sexual abuse were reported to them, they would secure the alleged victim and immediately call for a security staff member. A review of five allegation investigations indicated that none involved a non-security first responder.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy 14-2 DHS states, "Each facility will establish a Sexual Assault Response Team (SART) which includes the following positions: PSA Compliance Manager; Medical representative; Security representative; Mental health representative; and Victim Services Coordinator. The SART responsibilities include responding to reported incidents of sexual abuse and assault; responding to victim assessment and support needs; ensuring policy and procedures are enforced to enhance detainee safety; and participating in the development of practices and/or procedures that encourage prevention and intervention of sexual abuse and assault and enhance compliance with DHS PREA Standards." The Warden verified that staff first responders report an incident of sexual abuse to the Captain to assess the situation through a preliminary interview to gather information; then, the Captain immediately refers the detainee to medical and mental health, the Warden, AW, one of the two Chiefs, or ADO; the ADO notifies the Managing Director; the Captain also notifies the facility's qualified investigator and/or local law enforcement, if there is a criminal component; the facility leadership contacts the ICE Field Office.

(c)(d): Policy 14-2 DHS states, "If a victim of sexual abuse is transferred between facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." Interviews with the Warden and HSA confirmed that, if they were to transfer a victim of sexual abuse, all proper notifications would be made in accordance with the policy. The Warden, and PSA Compliance Manager, in their interviews, confirmed that TCDF had no instances of victim transfers between DHS or non-DHS facilities within the previous 12 months. A review of the TCDF policy 14-2 DHS indicated that the facility is not in compliance with subsections (c) and (d) of the standard. The standard requires a coordinated plan that includes, "if a victim of sexual abuse is transferred between facilities covered by subpart A or B of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medial or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise" which is not covered in either the plan or the policy. In an interview with the facility Commander, he indicated that he "assumed subsections (c) and (d) would be handled by ICE," thus confirming the facility has not included sections (c) and (d) in their coordinated response.

Does Not Meet (c)(d): The facility's policy 14-2 DHS, which doubles as their coordinated response plan, does not include the requirements mandated by subsections (c) and (d) of the standard. To become compliant, the facility must update the policy 14-2 DHS to include the language required by subsections (c) and (d) of the standard and to initiate the practice of informing the receiving facility covered by subpart (a) and (b) of the incident and the victim's potential need for medial or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, informing the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise." The facility must also conduct documented training of all applicable staff on the change in the policy 14-2 DHS that includes notifying facilities as required by the standard. In addition, if applicable, the facility must provide the Auditor with any detainee files where the detainee was transferred as a result of a sexual abuse allegation to confirm the facility is following the updated Sexual Response Plan.

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

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

Notes:

Policy 14-2 DHS states, "Staff suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Contractors and civilians [volunteers] suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies." The Warden confirmed that if any staff member, volunteer, or contractor was alleged to have perpetrated sexual abuse, they would be removed from all detainee contact pending the results of the investigative process. The Auditor reviewed two sexual abuse investigations that occurred during the audit period that included an allegation against staff. In the one reviewed file, the staff member was unknown, and therefore, the Auditor could not confirm if the staff member was removed from all duties as required by the standard. A review of the second sexual abuse investigation file confirmed the staff member was removed from detainee contact following an incident of sexual abuse until closed by the facility. As the sexual abuse investigation outcome was unsubstantiated, the staff member was returned to the detainee's housing unit. As the investigation was not forwarded to the JIC there is no closure date noted for ICE.

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

(a)(b)(c): Policy 14-2 DHS states, "Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least ninety (90) days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond ninety (90) days if the initial monitoring indicates a need to continuing need." The PSA Compliance Manager confirmed ninety (90) day retaliation monitoring is conducted by the designated staff, following a report of sexual abuse, to protect against potential retaliation against detainees or employees. This shall include periodic status checks of detainees and review of relevant documentation. Monitoring is documented on the 14-2D PREA Retaliation Monitoring Report form. Monitoring shall continue beyond ninety (90) days if the initial monitoring indicates a continuing need." The PSA Compliance Manager stated that a Unit Manager, Chief, or above would be assigned to monitor retaliation by reviewing housing changes, removing alleged staff or detainee abusers from contact with victims, providing emotional support services to staff or detainees who fear retaliation, reviewing detainee disciplinary reports, assessing staff negative performance reviews and staff reassignments. The PSA Compliance Manager further stated that such retaliation monitoring is conducted for at least 90 days. The Auditor thoroughly reviewed five sexual abuse allegation case investigative files that occurred during the audit cycle and confirmed 90-day retaliation monitoring was conducted and documented in three of the five cases. In the remaining 2 cases, the detainee was released from ICE custody between 1 to 15 days after the allegation was reported and retaliation monitoring was not required.

§115.68 - Post-allegation protective custody.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(c): Policy 14-2 DHS states, "The facility shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible." Policy 14-2 DHS further states, "A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a re-assessment taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." In informal interviews, the Restrictive Housing Sergeant, DOs, and the AW stated that protective custody is used as a last resort to house detainee victims of sexual abuse. In an interview, the PSA Compliance Manager stated that the facility houses the alleged sexual abuse victims in a separate housing unit from the alleged abuser; the PSA Compliance Manager stated that the facility completes a reassessment before returning a detainee victim to general population. In a memo submitted with the PAQ, the AW indicated that TCDF has not had an instance of segregating a detainee in order to protect them from sexual abuse.

(b)(d): Policy 14-2 DHS states, "Detainee victims shall not be held for longer than five (5) days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee." Policy 14-2 DHS further states, "Facilities shall notify the appropriate ICE Field Office Director no later than seventy-two (72) hours after the initial placement into segregation, whenever a detainee has been placed in segregation on the basis of a vulnerability to sexual abuse or assault." In an interview with the PSA Compliance Manager, it was indicated that detainee victims of sexual abuse are housed in protective custody or administrative segregation no longer than five days and that the ICE FOD is immediately notified whenever a detainee victim has been held in administrative segregation. The Warden, and PSA Compliance Manager, stated the facility notifies the ICE Field Office immediately by phone and email when a detainee has to be housed in protective custody. In a memo submitted with the PAQ the AW indicated that TCDF has not had an instance of segregating a detainee in order to protect them from sexual abuse.

§115.71 - Criminal and administrative investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a): Policy 14-2 DHS states, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators." A review of Policy 14-2 DHS does not require that the investigation be prompt, thorough, and objective. The facility's investigator verified that the facility conducts its own administrative investigations into sexual abuse allegations. The Warden and PSA Compliance Manager stated that the facility ensures administrative investigations into sexual abuse are prompt, thorough, and objective. The Auditor completed a thorough review of five randomly selected sexual abuse investigative files for the adjusted audit cycle and found the investigations were completed promptly by a trained investigator and appeared to be thorough and objective.

Recommendation (a): The Auditor recommends that the facility add the verbiage, "All investigations into alleged sexual abuse must be prompt, thorough, and objective."

(b): Policy 14-2 DHS states, "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or

appropriate." The Warden and the PSA Compliance Manager stated that TCDF's assigned investigator coordinates with EPD and the ICE Field Office when conducting an administrative sexual abuse investigation. The Warden, the PSA Compliance Manager, and the facility's investigator verified that if a criminal investigation is substantiated or unsubstantiated, the facility would conduct an administrative investigation. The auditor reviewed the one criminal investigation file and found an administrative investigation was conducted at the conclusion of the criminal investigation to verify compliance with this subsection.

(c): Policy 14-2 DHS states, "Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse and 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 alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse. Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment and investigation facts and findings; Discussions with ICE and local law enforcement should articulate a delineation of roles of the facility investigator and the law enforcement investigator to coordinate and sequence administrative and criminal investigations, to ensure that the criminal investigation is not compromised by an internal administrative investigation. Facility employees will assist the local law enforcement by preserving the integrity of the evidence so that cases are not lost based on lack of evidence, improper technique, and/or lack of credibility." The PSA Compliance Manager and the facility's investigator stated that the facility's investigator preserves direct and circumstantial evidence, conducts interviews with alleged victims, abusers, and witnesses, reviews prior sexual abuse complaints involving the alleged abuser, reviews video surveillance footage when it was available, and takes photos. The facility's investigator further stated that sexual abuse information is always documented and placed into the 5-1-IRD system, where all sexual abuse cases are stored and that only the facility investigator, Chief of Security, Unit Management, the Warden, and AW have access. The PSA Compliance Manager also verified that such information is retained after completion of the investigation. The Warden stated that once the facility's investigator has gathered evidence and information regarding the sexual abuse allegation, the facility's investigator would determine whether any failures at the facility led to the incident. The Auditor conducted five investigative file reviews. One allegation involved an incident that occurred at another facility and the detainee victim reported the incident to TCDF. The other four incident file reviews indicated that the administrative investigation included preservation of evidence, interviews with the victim, abuser, and witnesses, a description of evidence, preponderance of evidence, and/or the investigation report.

(e)(f): Policy 14-2 DHS states, "The departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." Policy 14-2 DHS further states, "When outside agencies conduct investigations of sexual abuse and assault, the facility shall cooperate with outside investigators and endeavor to remain informed about the progress of the investigation." The Auditor interviewed the Warden, PSA Compliance Manager, and the facility investigator. All interviewed indicated that the investigation would continue even after the alleged victim or abuser have been transferred or released from TCDF. In addition, the Warden, PSA Compliance Manager, and the facility's assigned investigator indicated that when outside agencies investigate sexual abuse, the facility cooperates with those agencies' investigators and remains informed about the progress of the investigation. The Warden further stated that the 5-1-IRD system flags (color coded) the Chief of Security to follow up with law enforcement.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Policy 14-2 DHS states, "In any sexual abuse investigation in which the facility is the primary investigating entity, the facility shall utilize a preponderance of the evidence standard for determining whether sexual abuse has taken place." The TCDF Investigator stated the evidence standard utilized when determining the outcome of a sexual abuse case is the preponderance of evidence. The investigator further stated that if at least 51% of the evidence points towards substantiation, they determine the incident is substantiated. The Auditor conducted a file review of five randomly selected sexual abuse allegation investigative files from the adjusted audit cycle, and it confirmed that all outcomes of the investigations were based on this standard of evidence.

§115.73 - Reporting to detainees.

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

Notes:

Policy 14-2 DHS states, "Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken. If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee." The Warden stated that the facility investigator informs detainees who reported sexual abuse verbally and in writing regarding the outcome of the external or internal investigation and any actions taken by the facility. The Auditor reviewed five randomly selected sexual abuse allegation investigative files and found two files that included an outcome notification form signed by the detainee and three files that contained the notification outcome form, but delivery could not be confirmed as the detainee was released from ICE custody; and therefore, the notification outcome form did not contain the detainee's signature.

§115.76 - Disciplinary sanctions for staff.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): Policy 14-2 DHS states, "Employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse. Disciplinary sanctions for violations of CoreCivic policies relating to sexual abuse (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the employee's disciplinary history, and the sanctions imposed for comparable offenses by other employees with similar histories. All terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, to the extent known." The Warden stated that the facility reports staff removals or resignations in lieu of removals, in writing or verbally, for violating sexual abuse policies in potentially criminal cases to EPD and the FOD and that the facility reports, in writing, staff removals or resignations in lieu of removals for violating sexual abuse policies to any relevant licensing bodies. The Warden further stated that staff is subject to disciplinary or adverse action up to and including removal from their position and federal service for substantiated allegations of sexual abuse or for violating facility policies; however, the facility is not in compliance with subsections (a), (b), (c), and (d) of the standard. Policy 14-2 DHS does not contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies," "removal from the Federal service, when there is a substantiated allegation of sexual abuse, or 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," "Each facility shall report all removals or resignations in lieu of removal for violation of Agency or facility sexual abuse polices to appropriate law enforcement agencies unless the action was clearly not criminal," and "Each facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of Agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known." A review of the five investigation files indicated that there were no staff removals or resignations in lieu of removals for violating sexual abuse policies to any relevant licensing bodies.

Does Not Meet (a)(b)(c)(d): The facility is not in compliance with subsections (a), (b), (c), and (d) of the standard. Policy 14-2 DHS does not contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies," "removal from the Federal service, when there is a substantiated allegation of sexual abuse, or 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." In addition, policy 14-2 DHS does not include the verbiage, "Each facility shall report all removals or resignations in lieu of removal for violation of Agency or facility sexual abuse polices to appropriate law enforcement agencies unless the action was clearly not criminal," and "Each facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of Agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known." To become compliant with subsections (a), (b), (c), (d) the facility must update Policy 14-2 DHS to include the required verbiage of the standard and must submit documentation that the updated Policy 14-2 DHS was submitted to the Agency for review and approval. In addition, if applicable, the facility must provide investigation files that confirm a staff member was disciplined in accordance the standard 115.76 after an incident of substantiated sexual abuse.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c): Policy 14-2 DHS states, "Contractors and civilians suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards. Incidents of Substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall report such incidents to the ICE Field Office Director/designee regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." The Warden verified that the facility's policy on addressing sexual abuse allegations involving contractors or volunteers includes the following: prohibits contractors or volunteers who have engaged in sexual abuse from contact with detainees, removes contractors or volunteers suspected of sexual abuse from all duties that requires detainee contact until the investigation is completed, reports potentially criminal allegations to law enforcement agencies, reports substantiated incidents to relevant licensing bodies, and takes remedial measures, including prohibiting contact for contractors or volunteers who have violated other provisions within DHS PREA. The Warden further stated that there were no reported incidents requiring the removal of a contractor or volunteer within the audit period which the auditor confirmed through investigative file reviews.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c): Policy 14-2 DHS states, "Detainees shall 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; Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for

comparable offenses by other detainees with similar histories." The Warden indicated that TCDF has progressive levels of reviews, appeals, and procedures and documents such procedures by using the disciplinary form. The Warden also stated that the facility disciplines detainees who have engaged in sexual abuse by using sanctions commensurate with the severity of the incident and sanctions intended to encourage detainee to conform to rules in the future. The Auditor reviewed the facility detainee handbook and further confirmed that the detainee discipline process meets sections (a)(b) and (c) of the standard in all material ways. In a memo dated March 16, 2022, authored by the Warden, it indicated there has been no instances of disciplinary sanctions against a detainee related to PREA during this audit review period. However, the Auditor reviewed the investigative file of the one detainee-on-detainee substantiated sexual abuse allegation and confirmed the alleged perpetrator was placed in segregation and did receive institutional discipline.

(d): Policy 14-2 DHS states, "If a detainee is mentally disabled or mentally ill, but competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed." During his interview, the Warden verified that the facility's disciplinary sanctions take into consideration whether a detainee's mental illness may have contributed to the infraction.

(e)(f): Policy 14-2 DHS states, "A detainee may be disciplined for sexual conduct with an employee only upon a finding that the employee did not consent to such contact; Detainees who deliberately allege false claims of sexual abuse can be disciplined. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation…The Facility Administrator or designee may contact law enforcement to determine if a deliberately false accusation may be referred for prosecution." During his interview, the Warden stated that TCDF would not discipline a detainee for making a report of sexual abuse in good faith even if the investigation did not establish enough evidence to substantiate the incident. The Warden also stated that TCDF would not discipline a detainee for consensual sexual contact with a staff member.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 14-2 DHS states, "If the screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than seventy-two (72) hours after the referral." The two intake officers interviewed confirmed that any detainee disclosure of prior victimization, during intake, requires the detainee be immediately referred to medical. The vulnerability assessment is entered electronically into the Offender Management System (OMS) and if a checkmark is made on the document a referral email is immediately forwarded to medical and mental health for follow up. The HSA and Mental Health Coordinator confirmed when this medical follow-up/referral is initiated, the detainee receives a health evaluation typically the same or next day and no later than two working days from the date of the assessment. When a referral for mental health is initiated, the detainee receives a mental health evaluation no later than 72 hours after the referral. The Mental Health Coordinator further stated any detainee found to have perpetrated sexual assault/abuse would be moved to another facility. The facility submitted a detainee file of a transgender detainee submitted prior to the on-site audit. Although the file confirmed that the detainee had experienced prior sexual abuse, the review of the file could not confirm that the detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate or that the detainee was seen by either practitioner in the timeframes required by the standard.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), or (c) of the standard. The facility submitted a detainee file of a transgender detainee prior to the on-site audit. Although the file confirmed that the detainee had experienced prior sexual abuse, the review of the file could not confirm that the detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate or that the detainee was seen by either practitioner in the timeframes required by the standard. To become compliant, all intake, medical, and mental health staff must be trained in the requirements of policy 14-2 DHS and the standard. In addition, the facility must document said training. The facility must also provide the auditor, if applicable any detainee files, medical files, and/or mental health files of a detainee who experienced prior sexual abuse to confirm the detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate and that the detainee was seen by either practitioner in the timeframes required by the standard.

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

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

Notes:

(a)(b): Policy 14-2 DHS states, "Detainee victims of sexual abuse and assault shall 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. All treatment services, both emergency and ongoing, shall 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." Policy 14-2 DHS further states, "Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related

medical services." Interviews with the HSA confirmed that a detainee requiring a forensic examination is sent to the UNMH, and all treatment services, to include emergency medical treatment and crisis intervention services, including sexually transmitted infections prophylaxis, are provided without cost and with professionally accepted standards of care. TCDF had no detainees sent out for a forensic examination or medical treatment for sexual abuse during the audit period. The Auditor's review of five randomly selected investigative files and the associated medical files reviewed confirmed detainees were immediately seen by medical staff at the time the facility became aware of the allegation. The interview with the HSA confirmed victims of sexual abuse would be transported to the Albuquerque SANE Collaborative for treatment as outlined in the MOU dated March 10, 2022, with no expiration date.

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

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

Notes:

(a)(b)(c)(d)(e)(f): Policy 14-2 DHS that requires, "The facility shall 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 shall 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. The facility shall provide 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 shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services." Policy 14-2 DHS further requires, "All treatment services, both emergency and ongoing, shall 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." The HSA confirmed all detainees, who experience sexual abuse while in detention, receive medical and mental health services consistent with the community-level of care, evaluation, and treatment without cost, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. The HSA also confirmed the medical and mental health departments at TCDF provide on-site crisis intervention services, if necessary, to include, sexually transmitted infections and other infectious diseases testing, and prophylactic treatment to victims, if necessary. The Auditor reviewed five randomly selected sexual abuse allegation investigative files and documentation from their medical files from the adjusted audit cycle and found the detainees in each case were immediately seen by medical upon reporting the allegation and referred to mental health.

(g): Policy 14-2 DHS states, "The facility shall attempt to conduct a mental health evaluation of all known Detainee-on-Detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." The interview with the PSA Compliance Manager and HSA, who oversees Mental Health, confirmed that all known abusers would be offered services consistent with the policy and standard. There was one allegation of substantiated sexual abuse during the adjusted audit cycle. The detainee subject was immediately transferred prior to any mental health referral. According to the PSA Compliance Manager and the HSA, the receiving facility was notified.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 14-2 DHS states, "The Facility Administrator will ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be Unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation; The facility shall implement the recommendations for improvement or shall document reasons for not doing so. The 14-2F-DHS Sexual Abuse Incident Review Report shall be forwarded to the PSA Coordinator and the ICE Prevention of Sexual Assault (PSA) Coordinator through the local ICE Field Office." Policy 14-2 DHS further states, "In addition to the Facility Administrator, the incident review team shall include upper-level facility management and the facility SART, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse…Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse." The PSA Compliance Manager verified that the facility considers whether the incident was motivated by race, ethnicity, gender identity, LGBT status, gang affiliation, or by other group dynamics and that the facility conducts an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. The PSA Coordinator further stated, if the facility has not had any reports of sexual abuse during the annual reporting period, then the facility would prepare a negative report and that the results and findings of the annual review will l be provided to the Facility Administrator, FSC PSA Coordinator, and the ICE PSA Coordinator through the local ICE Field Office." The Warden stated that the facility conducts an incident review at the end of every investigation of sexual abuse. He stated that such reviews are completed within 30 days and is documented in the 5-1-IRD system. The PSA Compliance Manager reported that the facility's process for conducting sexual abuse incident reviews includes conducting a sexual abuse incident review at the conclusion of every investigation of sexual abuse, conducting the incident review within 30 days of receiving the investigation results, preparing a written response for every substantiated or unsubstantiated allegation, documenting in the written report whether a change in policy or practice could better prevent or respond to sexual abuse, implementing recommendations for improvement, and forwarding the report and response to the ICE PSA Coordinator. The PSA Compliance Manager further stated this process is achieved through the SART meetings with the corporate office via phone conferencing. The Auditor reviewed five investigative files that

occurred during the audit period and confirmed that the four investigative files that indicated the incident occurred at the facility confirmed that the incident reviews contained all required elements of the standard, and were incident completed within 30 days.

The Warden confirmed that the facility has received reports of sexual abuse during the audit period and that if the facility did not receive such report, a negative report would have been completed. The Warden further stated that the facility conducts an annual review of all sexual abuse allegations along with resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts to the ICE FOD and Agency's PSA Coordinator. The Auditor reviewed the annual report submitted with the PAQ and confirmed it was completed by the facility administrator and forwarded to the ICE FOD. The document did not confirm the report was forwarded to the Agency PSA Coordinator.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed the annual report submitted with the PAQ and confirmed it was completed by the facility administrator and forwarded to the ICE FOD. The document did not confirm the report was forwarded to the Agency PSA Coordinator. To become compliant the facility must document that the completed Annual PREA report was forwarded to the Agency PSA Coordinator.

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

(a): Policy 14-2 DHS states, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be retained in accordance with CoreCivic Policy 1-15 Retention of Records." The PSA Compliance Manager confirmed that sexual abuse case records are maintained in the AW's office in a locked file cabinet.

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

(d): The Auditor was allowed access to the entire facility and able to interview staff and detainee about sexual safety during the audit visit.
(e): The Auditor was able to revisit areas of the facility and to view all relevant documentation as requested.
(i): Formal interviews with staff, contractors, volunteers, and detainee were conducted in a private confidential setting.
(j): Audit notices were posted and observed throughout the facility in English and Spanish. The Auditor received no staff or detainee correspondence.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	28
Number of standards not met:	11
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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.

Cicily Harrington 5/15/2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) 6/23/2022
Program Manager's Signature & Date

(b) (6), (b) (7)(C) 6/23/2022
Assistant Program Manager's Signature & Date