PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	12/7/2021	**To:**	12/9/2021
AUDITOR INFORMATION			
Name of auditor:	Cicily Harrington	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Harlingen Field Office		
Field Office Director:	(A)FOD Cammilla Wamsley		
ERO PREA Field Coordinator:	SDDO (b) (6), (b) (7)(C)		
Field Office HQ physical address:	1717 Zoy Street Harlingen, TX 78552		
Mailing address: (if different from above)	N/A		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Laredo Processing Center		
Physical address:	4702 E. Saunders, Laredo, TX 78041		
Mailing address: (if different from above)	Same as above		
Telephone number:	956-727-4118		
Facility type:	D-IGSA		
PREA Incorporation Date:	Click or tap to enter a date.		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	956-727-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Chief of Security
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	956-727-(b) (6), (b) (7)(C)
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 Laredo Processing Center (LPC) was conducted on December 7-9, 2021, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditors, Cicily Harrington and [redacted] for Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigrationa and Custom Enforcement (ICE) PREA Program Manager, [redacted] and Assistant Program Manager [redacted], DOJ and DHS certified PREA Auditor. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE External and Analysis Unit (ERAU) section during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The LPC is privately owned by CoreCivic and operates under contact with the DHS,(ICE), Office of Enforcement and Removal Operations (ERO). The facility currently processes adult female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the LPC are from El Salvador, Mexico, and Honduras. The facility does not house juveniles, males, or family detainees. This was the second DHS PREA audit for the LPC and the facility is located in Laredo, Texas.

On December 7, 2021, an entrance briefing was held in the LPC administrative conference room. The ICE Office of Professional Responsibility (OPR) ERAU Team Lead, [redacted], opened the briefing via telephone and then turned it over to the Auditor. In attendance were:

CoreCivic Staff	ICE Staff	Creative Corrections
Orlando Perez, Warden	[redacted], Team Lead	Cicily Harrington, certified PREA Auditor
[redacted], Quality Assurance	[redacted], AFOD	[redacted], Program Manager
[redacted], Chief of Security	[redacted], SDDO	
	[redacted], DO/COR	
	[redacted], DO/COR	

The Auditor introduced herself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. The Auditor explained the audit process is designed to assess the facility and agency's compliance through written policies and procedures as well as common practice. The auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the onsite facility tour, provided documentation review, and interviews with staff and detainees. On the first day of the audit, there were 160 detainees housed at the LPC.

The Laredo Processing Center, owned and operated by CoreCivic, is located at 4702 E. Saunders, Laredo, Texas. The facility is made up of one building with a current rated capacity of 404, which includes six single occupancy cell housing units, seven open bay/dorm housing units, two medical unit/infirmary beds, two mental health unit beds, four administrative and disciplinary restrictive housing cells, and seven multiple occupancy cell housing units.

During the onsite audit tour, the auditors conducted informal interviews with staff and detainees, inquiring their knowledge of PREA. At the conclusion of the tour, the auditors were provided with staff and detainee rosters (all three shifts) and randomly selected from each for formal interviews. A total of 13 staff were interviewed including four specialized staff (the Warden, PSA Compliance Manager, Training Manager, and Grievance Coordinator), three security staff/line supervisors (random staff), a Registered Nurse, two Licensed Practical Nurses, one volunteer, the Assistant Food Service Director, and the Clinical Supervisor. The Auditor conducted random interviews with 10 detainees, and five interviews with detainees in the targeted populations of limited English proficiency (LEP) (3) and those who reported a history of sexual abuse (2) as they were physically present at the facility during the on-site audit. The random detainee's interviewed also happened to be LEP; all LEP detainees interviewed required the use of a language line through Language Line Solutions provided by facility. There were neither any reported detainees with a physical, mental, and/or intellectual disability nor were there any reported lesbian, bisexual, gay, transgender, questioning, or intersex detainees available for interview at the time of the onsite audit. During the onsite tour, the PSA Compliance Manager reported that detainees who are blind or with limited sight are provided individualized service by the intake staff to include reading information to the detainee if needed.

During the audit tour, the auditors visited the following areas: (1) post seven & eight, (2) dorm six, (3) laundry room, (4) small recreation yard, (5) attorney room, (6) medical/infirmary, (7) dorm seven, (8) restrictive/segregation housing, (9) intake, (10) kitchen, (11) shift supervisor office, (12) law library, (13) asylum rooms, (14) post six, (15) barbershop, (16) commissary room, (17) dorm one, (18) commissary officer, (19) all-purpose room, (20) electrical room, and (21) control center. Throughout the listed areas, the auditors observed CoreCivic, ICE, and DHS Office of Inspector General (OIG) PREA signages along with the ERO Language Services. The auditor also observed video surveillance cameras situated throughout the housing units to capture the view of all housing unit bunks. Such areas were cited as blind spots in the facillity's 2018 PREA audit. The auditors were escorted by male staff and upon entering the

housing units, the female unit officer would announce, "male entering unit." Also, the female unit officer would conduct a walkthrough of the unit to ensure there were no detainees in the shower and restroom areas prior to the male staff entering the housing units to prevent cross-gender viewing.

In accordance with the PAQ, there were two allegations of sexual abuse reported at LPC during this 12 month audit period. The 12-month audit review period was from 12/6/20 through 12/6/2021. The facility reported two PREA allegations during this review period, however, one of two allegations reported by the facility was deemed non-PREA by the agency; and as such, the Auditor did not include this allegation in their sample case file review for compliance determination. The auditor reviewed the one closed investigative file during this audit and found it was referred to ICE OPR and determined to be unsubstantiated after investigation by the LPC investigator. The facility uses its own trained PREA investigators to conduct administrative investigations of sexual abuse, and it partners with the LPD to conduct sexual abuse allegations that may have a criminal component. The interviews with the Warden and the PSA Compliance Manager indicated that all criminal allegations of sexual abuse are referred to LPD.

On December 9, 2021, an exit briefing was held in the LPC administrative conference room. The ICE ERAU Team Lead, Wendy Webb, opened the briefing via telephone and then turned it over to the auditor. In attendance were:

CoreCivic Staff	**ICE Staff**	**Creative Corrections**
Orlando Perez, Warden	(b) (6), (b) (7)(C) Team Lead	Cicily Harrington, certified PREA Auditor
(b) (6), (b) (7)(C), Quality Assurance	(b) (6), (b) (7)(C), AFOD	(b) (6), (b) (7)(C), Program Manager
(b) (6), (b) (7)(C) Chief of Security	(b) (6), (b) (7)(C), SDDO	
	(b) (6), (b) (7)(C), DO/COR	
	(b) (6), (b) (7)(C), DO/COR	

The auditor discussed her observations made during the onsite audit. The auditor observed that staff were knowledgeable of their responsibilities as it pertains to PREA and ensuring detainees in their care were appropriately supervised. The detainees demonstrated their knowledge of having the right to be free from all forms of sexual abuse and were also knowledgeable on the facility and agency's reporting methods. The auditor briefly explained that there was a discrepancy with at least one of the standards but would have to receive some more guidance and clarification. The auditor also briefly explained that some of the concerns were brought to the facility's attention and immediately abated while the auditors were still onsite. The team was advised that further review of policies, procedures, interviews, auditors' notes, and supporting documentation would have to be conducted prior to the auditor providing a sound determination of compliance or non-compliance with each of the PREA standards.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2

§115.18 Upgrades to facilities and technologies
§115.35 Specialized training: Medical and Mental Health Care

Number of Standards Not Applicable: 1

§115.14 Juvenile and family detainees

Number of Standards Met: 38

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services §115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.71 Criminal and Administrative Investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews.
§115.87 Data collection

Number of Standards Not Met: 0

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) The facility reported that it has a written policy mandating zero tolerance toward all forms of sexual abuse and outlining its approach to preventing, detecting, and responding to such conduct. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg.1-2)* states, "CoreCivic maintains a zero-tolerance policy for all forms of sexual abuse or assault. The auditor confirmed the 14-2-DHS policy was approved by the AFOD. It is the policy of CoreCivic to provide a safe and secure environment for all detainees, employees, contractors, and volunteers that is free from the threat of sexual abuse or assault. CoreCivic provides a Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program "that ensures effective procedures for preventing, reporting, responding to, investigation, and tracking incidents or allegations of sexual abuse or assault." The auditor reviewed the facility's post orders which outlines the facility's approach to prevent, detect, and respond to all forms of sexual abuse. Given the information provided, the auditor determined that the facility meets the requirement of this standard provision.

(d) According to the PAQ, the facility employs or designates a Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager) who shall serve as the facility point of contact for the agency PSA Coordinator and who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. The auditor reviewed the facility's organizational chart revised in February 2021 and observed that the PREA Compliance Manager reports directly to the Warden. During the onsite audit interview with the PSA Compliance Manager, the auditor was informed that the PSA Compliance Manager's job is to ensure the facility follows policy and follow through with PREA issues and "take them seriously." He reported that he is the facility's point of contact for ICE's PSA Coordinator. The PSA Compliance Manager confirmed having sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. Given the information provided, the auditor determined that the facility meets the requirement of this standard provision.

§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) Prior to the onsite audit, the documentation submitted with the PAQ indicated that the facility maintains sufficient supervision of detainees, including through appropriate staffing levels, and where applicable, video monitoring, to protect detainees against sexual abuse. According to the 2020-2021 PREA Staffing Plan, LPC has a supervisor assigned to each of its three shifts with a total of seven detention officers assigned to supervise detainees in the facility's seven dormitories in addition to the restrictive housing unit. There were no detainees housed in restrictive housing during the on-site audit. The Auditor was provided and reviewed the LPC staffing plan, facility layout diagram and during the three days the Auditor was on-site she observed, on each of the eight-hour shifts, the adequate supervision of the detainees. Contract and volunteer services as well as ICE ERO are included in the Staffing Plan. Given the information provided, the auditor determined that the facility meets the requirement of this standard provision.

(b)(c) Documentation submitted with the PAQ indicated that LPC develops and documents comprehensive supervision guidelines to determine and meet its detainee supervision needs. The PSA Compliance Manager also reported that the comprehensive supervision guidelines are reviewed at least annually. In addition, the Shift Supervisor and the Quality Assurance Manager reported through the PAQ that LPC takes generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in agency custody into consideration when developing comprehensive supervision guidelines. *Post Order COR-PO-00*, dated 09/19/17, outlines the detention officer's duties for ensuring the facility's detainee supervision needs by conducting security checks, monitoring detainee movement, searches, reporting all sexual abuse and sexual harassment complaints. Auxiliary post orders also outline staff's responsibilities for supervising detainees. The auditor reviewed the *Policy Document Review/Revision Request*, which indicates a listing of policy updates signed by the Warden. During the onsite audit, the Warden stated that 30-minute security checks are conducted by officers on post, and that supervisors and the ADO are responsible for conducting weekly rounds on each shift. The Warden reported that corporate leadership develops a staffing pattern based on correctional standards. He stated that the facility reviews it every year. He further stated that there are some posts that cannot be left alone. The Warden stated that he and the PSA Compliance Manager review supervision guidelines and return them back to corporate to ensure they are all in agreement. He reported that they are always vigilant of their postings and that they look for blind spots, weaknesses, and any need for changes. Also, the Warden stated that supervisors conduct at least one security round per shift. He reported that the staffing ratio is one employee to six detainees and that the ratio for the entire facility is 1.3 staff to five detainees (note: the Auditor recognizes the inconsistency between the interview and staffing plan; however, has deemed this inconsequential given observatiosn during the on-site audit further support compliance with the pre-approved staffing plan). During the PSA Compliance Manager's interview, he reported, "the facility usually has a staffing plan and physical plan." He stated that only females are housed at LPC, and

that they make sure female officers are available and cameras are working to eliminate blind spots. He reported that the facility has a total of seven dormitories to house detainees. He reported that the facility has more than 90 cameras. The PSA Compliance Manager also reported that post orders are reviewed annually which goes through the Warden for approval and that video monitoring and security checks are included in the Staffing Plan as well. Documentation submitted with the PAQ indicated that all post orders were reviewed and approved November 12, 2020 and that there was no need for changes. Given the information provided, the auditor determined that the facility meets the requirement of this standard provision.

(d) Documentation submitted with the PAQ indicated that frequent unannounced security inspections are conducted to identify and deter sexual abuse of detainees and that such inspections are implemented for night as well as day shifts. *Post Order COR-PO-02*, dated 09/19/17, outlines the assistant shift supervisor's duties for ensuring the facility's detainee supervision needs by conducting unannounced rounds on all shifts, including nights, to identify and deter sexual abuse and sexual harassment. In addition, Post Order COR-PO-02 reported that staff is prohibited from alerting others that these security inspections are occurring, unless such announcement is related to the legitimate operational functions of the facility. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg.11, sec. C4a.)* states, "Staff, including supervisors, shall conduct frequent unannounced security inspections rounds to identify and deter sexual abuse of detainees…" *Post Order COR-PO-02* dated 09/19/17 outlines the assistant shift supervisor's duties for ensuring the facility's detainee supervision needs by conducting unannounced rounds on all shifts, including nights, to identify and deter sexual abuse and sexual harassment. *Post Order COR-PO-00* dated 09/19/17 outlines the detention officer's duties for ensuring the facility's detainee supervision needs by conducting security checks, monitoring detainee movement, searches, reporting all sexual abuse and sexual harassment complaints. The facility provided a copy of nine logbook entries representing different days of the week, on all three shifts, including nights, indicating that a PREA walkthrough inspection had been conducted in the detainee housing units and auxiliary posts. When asked, three staff/line supervisors stated that frequent unannounced security inspections are conducted. Also, during the onsite audit tour, several uniformed staff members reported that security inspections are conducted frequently, specifically during the holiday season. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a-d) In accordance with the PAQ, interviews with the WardenWarden, specialized and random staff, LPC does not house juvenile detainees. Neither did the auditor review documentation pertaining to LPC housing juvenile detainees, nor did the auditor observe any juvenile detainees in the facility during the onsite audit. AFOD memorandum dated 09/24/21 stated that LPC does not house juvenile detainees. Given the information provided, this standard does not apply.

§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) Policy*14-2 DHS Sexual Abuse Prevention and Response (pg.16, sec. G1a.)* states, "When operationally feasible, staff conducting a search must be of the same gender, gender identity, or declared gender as the detainee being searched." During the pre-onsite audit, the facility reported through the PAQ that it does not currently house male detainees. However, Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 16, sec. G1b.)* states, "Pat searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required, or, in exigent circumstances." The PAQ also indicated that there was no pat down searches of male detainees by female staff in the last 12 months. The facility's Detainee Handbook indicates the importance of searches to ensure safety of officers, civilians, and detainees. During the onsite audit, the auditor did not observe any male detainees in the facility's custody while conducting the onsite facility tour. The Warden, specialized, and random staff reported in their interviews that LPC did not house male detainees. Also, the detainee file reviews conducted by the auditor did not reflect any male detainees being currently housed in the facility. Given the information provided, the auditor determined that this provision does not apply.

(c-f) Documentation submitted with the PAQ indicated that there was no cross-gender pat down searches conducted on detainees by staff of the opposite gender in the last 12 months. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 16, sec. G1c. and C1d.)* states, "Pat searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All cross-gender pat searches of detainees will be documented in a logbook including details of exigent circumstances." During the onsite audit interviews, the Warden, the PSA Compliance Manager, and random staff reported that such searches of female detainees are not conducted unless in exigent circumstances and shall be documented. A file review of 10 detainees confirmed there were no cross-gender pat searches of female detainees. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision. Documentation submitted with the PAQ indicated that cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. The PAQ indicated that the facility documents all strip searches and visual body cavity searches. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 16-17, sec. C1e., C1g. and G1i.)* states, "Strip searches of detainees by staff of the opposite gender shall not be conducted except in exigent circumstances, or when performed by medical practitioners. An officer of the same gender as the detainee shall perform strip searches. AFOD memorandum dated 09/24/21 stated that there has not been a strip or visual body cavity search conducted at the facility during this audit period. The auditor conducted 10 random detainee file reviews and there was no indication of a strip or visual body cavity search conducted at the facility during this audit period. In the case of an emergency, a staff member of the same gender as the detainee shall be present to observe a strip search performed by an officer of the opposite gender. When an officer of the opposite gender conducts a strip search which is

observed by a staff member of the same gender as the detainee, staff shall document the reasons for the opposite gender search in any logs used to record searches and in the detainee's detention file. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 16-17, sec. C1h.)* states, "Body cavity searches will only be conducted by a medical professional and take place in an area that affords privacy from other detainees and from facility staff who are not involved in the search… All strip searches of and visual body cavity searches shall be documented." Also, the facility reported through the PAQ that it does not house juvenile detainees. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 16, sec. C1f.)* states, "Staff shall not conduct strip searches of juveniles. All such body cavity searches of juveniles shall be referred to a medical practitioner." The Warden, specialized, and random staff reported that juveniles are not housed in LPC. The auditor observed no juveniles housed in LPC during the onsite audit. AFOD memorandum dated 09/24/21 stated that there has not been a strip or visual body cavity search conducted at the facility during this audit period. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(g)Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 16, sec. G2a.)* indicated "hat detainees are 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." In addition, the PAQ indicated that staff of the opposite gender announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing. During the onsite audit tour, the auditor observed large cameras situated in the center of the detainee housing units to capture all areas throughout the unit. The auditor was concerned of cross-gender viewing while showering, bathing, changing clothes and using the restroom. Therefore, the auditor requested the control room to maximize the camera footage of the shower and restroom areas and observed that the camera system has a "block out" mechanism that prohibits the staff in the control room from monitoring detainees while unclothed in these areas. When asked, the auditor was informed that the facility does not have the capability to override the "block out" mechanism; only headquarters has this capability. The shower, changing, and toilet areas were blocked off by cinderblock partitions which allowed for staff to effectively conduct security inspections while providing privacy to the detainees. The auditor was concerned that the half wall partitions in the shower areas were not high enough to allow for detainee privacy. Therefore, during the onsite audit tour, the auditor had a staff person over six feet stand behind the partition. The auditor observed that the partition was tall enough to allow such privacy. Also, each toilet area had a half wall partition and a curtain in front of each open stall to allow for detainee privacy. The shower entrances had a curtain with netting at the top to allow for effective security inspections while still providing privacy to the detainees. The auditor conducted 10 random detainee interviews and was informed by all 10 detainees that staff of the opposite gender have never seen them showering, bathing, or using the restroom. Eight out of 10 random detainees reported that they feel they have privacy to use the bathroom shower, or bathe, without being seen by staff of the opposite gender. Nine of the 10 random detainees reported that staff of the opposite gender announce their presence prior to entering their housing unit. The auditor observed this practice during the audit tour. Prior to a male entering the housing units, the female officer checks the shower and restroom areas and announces that a male is entering the unit. The female officer did not allow the male staff member to enter the housing unit until all females were out of the shower and restroom areas. The auditors conducted four specialized staff interviews, three non-security contractor interviews, one volunteer interview, two non-security first responder interviews, and three security staff/line supervisor interviews which totals 13 staff interviews. When asked, staff reported that upon a male entering the housing units, the male staff announces himself by stating "male on unit." Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(h) LPC is not a Family Residential Facility; and therefore, the auditor determined this provision to be non-applicable.

(i) During the pre-onsite audit, the PAQ indicated that the facility refrains from searching or physically examining any detainee for the sole purpose of determining the detainee's gender. Also, the PAQ indicated that if a detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. During the onsite audit tour, the auditor was informed by the PSA Compliance Manager that the facility does not conduct searches or physical examinations of any detainee to solely determine the detainee's gender. The auditor conducted 10 random detainee file reviews and there was no indication of such practice. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(j) In accordance with the PAQ, the facility and agency reported that security staff are trained on proper procedures for conducting pat-down searches, including cross gender pat-down searches and searches of transgender and intersex detainees. The facility also reported that pat-down searches are conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. The *Searches Training Curriculum* addresses proper procedures for conducting the above searches. There were 26 training rosters provided to confirm that 70 facility staff had received training on the proper procedures for conducting the above searches. During the onsite audit, the auditor interviewed three security staff/line supervisor staff members and each reported that they received training on how to conduct a pat-down search. The training manager confirmed that security staff are trained on proper procedures for conducting such searches. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

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

(a-b) In accordance with the PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 20, sec. J1a.)* submitted during the pre-onsite audit, ICE and LPC take appropriate steps such as providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively using any necessary specialized vocabulary to ensure that detainees with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse. In addition, the facility reported through the PAQ that it ensures any written materials related to sexual abuse are provided in formats or through methods that ensure effective communication with detainees with disabilities, including detainees who have intellectual disabilities, limited reading skills, or who are blind or have low vision. Also, the Warden reported that reasonable steps are taken to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited English speaking. The facility's contracted language line provides 24 hour interpative services for detainees. The LPC's Detainee Handbook indicates that TTY telephone machines are available for detainees with a hearing impairment. The Handbook also provides information on PREA and how to report sexual abuse. ICE zero tolerance posters provide information in multiple languages to include English and Spanish, how to report sexual abuse to staff, an ICE official, or outside entity such as the DHS OIG, the facility PREA Compliance Manager, and San Antonio Rape Crisis Center information. The auditor observed these posters on the detainee housing unit bulletin boards during the onsite audit tour. During the onsite audit, the auditors conducted 10 detainee file reviews. According to the file reviews, all 10 detainees were LEP. Specialized assistance such as the language line or a staff interpreter was used to provide PREA education to eight of the 10 detainees. There were no reported detainees with any disability outlined in this standard. Also, During the onsite audit, the auditors conducted four specialized staff interviews, three non-security contractor interviews, one volunteer interview, two non-security first responder interviews, and three security staff/line supervisor interviews which totals 13 staff interviews. When asked, four uniformed officers reported that they have communicated with a detainee who has intellectual, psychiatric, speech disabilities or LEP. An interview with the PSA Compliance Manager indicated that upon intake, detainees are provided with the ICE National Detainee Handbook which is available in English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. He also advised the detainee tablets are available in detainee living areas that include facility orientation materials in these same 14 languages. During the interviews, the three targeted LEP detainees stated that they spoke Spanish and reported they do not need help communicating with staff or reading facility materials as this information is provided in Spanish as well as English. All three reported that they were able to communicate with staff upon arrival. The Warden stated, during his onsite interview, that written information is provided to detainees through the Detainee Handbook and bulletin board postages. He reported that the facility provides other accommodations or assistive devices, and that the facility has not been unable to provide such accommodations upon request. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(c) During the pre-onsite audit, the facility reported that the agency and LPC provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 20, sec. J1a.)* also provided the above information. When asked, four employees (Warden, PSA Compliance Manager, Training Manager and Grievance Coordinator), reported that they have either communicated with a detainee who has intellectual, psychiatric, speech disabilities or LEP. They reported that resources such as the facility's Detainee Handbook, ICE Handbook, or the language line would be used to assist detainees with reporting sexual abuse. During the onsite audit, the auditor interviewed three targeted LEP detainees and was informed that PREA information was provided in their language by staff interpreters. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

§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) A review of the updated PAQ indicated that the agency and facility refrain from hiring, promoting, or enlisting the services of any employee, contractor, or volunteer who may have contact with detainees who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. *Policy 14-2–DHS Sexual Abuse Prevention and Response*, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive that require outline how the facility and agency, to the extent permitted by law, can refuse to hire or promote anyone who may have contact with residents, and decline to enlist the services of any contractor or volunteer who may have contact with residents, who has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard. The facility's policy requires new hires, staff awaiting promotions and all staff annually to complete and submit a 14-2H-DHS Self-Declaration of Sexual Abuse/Sexual Harassment form. The individual will respond directly to questions about previous misconduct as required per the standard and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The form is to be retained in the employee's personnel file. Policy further indicates every effort is to be made to contact all prior institutional employers for information on sexual abuse incidents prior to hiring. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 6, sec. B2a.)* 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 (as defined in 42 U.S.C 1997); Has been convicted of a engaging or attempting to engage in sexual activity facilitated by force, overt, or implied threats

of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in such activity as outlined above in B.2.a.2. (115.17 (a))." The auditor interviewed the Human Resources (HR) staff person who stated the facility would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated the employee is required to sign a release of information document in this case. She also stated the facility, along with ICE, would request information from prior institutions where the prospective candidate was previously employed during background checks. During the onsite audit, the auditor conducted 10 random employee file reviews and found that all 10 employees had a thorough background investigation and ICE approvals to hire the staff member prior to their actual start date. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(b) In accordance with the PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 7, sec. B2c.)* provided during the pre-onsite audit, applicants, employees, and contractors who may have direct contact with detainees shall be asked about previous misconduct, as outlined in this standard. This information may be asked 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 PAQ also reported that the agency and facility impose upon employees a continuing affirmative duty to disclose any such misconduct. In addition, Policy*14-2 DHS Sexual Abuse Prevention and Response (pg. 7, sec. B2c2.)* states that continuing affirmative duty to disclose any sexual misconduct as outlined in this standard is imposed by using the 14-2H-DHS Self Declaration of Sexual Abuse form which will be completed upon application for employment and as part of the promotional interview process. This form is signed annually by each employee, contractor, and volunteer. A copy of the signed form for employees and contractors is maintained in the Human Resources Department's file while a copy of the signed form for volunteers is maintained in the Human Resources Department's file and/or Volunteer Services Coordinator's training file. Policy*14-2 DHS Sexual Abuse Prevention and Response (pg. 7, sec. B2e)* states, "Consistent with federal, state, and local law each CoreCivic facility shall make its best effort to contact all prior institutional employers for information on its Substantiated allegations of sexual abuse or resignation during a pending investigation of an allegation of sexual abuse as defined by this policy." Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(c) During the pre-onsite audit, the auditor's review of the PAQ indicated that before hiring new staff who may have contact with detainees, the agency or facility shall conduct a background investigation to determine whether the candidate for hire is suitable for employment with the facility or agency, including a criminal background records check. The PAQ indicated that upon request by the agency, it shall submit for the agency's approval written documentation showing the detailed elements of the facility's background check for each staff member and the facility's conclusions. *Policy 14-2- DHS Sexual Abuse Prevention and Response*, and *ICE Directives 6-7.0 & 6.8.0* requires the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with residents prior to being allowed entrance into the facility. It further requires a background recheck be conducted every 5 years on all employees and unescorted contractors. The Human Resource Manager stated ICE completes all background checks for all ICE staff, staff and contractors. Policy*14-2 DHS Sexual Abuse Prevention and Response (pg. 7, sec. B2d)* states, "Before hiring new employees who may have contact with detainees, each CoreCivic facility shall: Require a criminal records background check (115.17(c))." The PAQ indicated that the agency and the facility conduct an updated background investigation every five years for agency and facility employees who may have contact with detainees. Policy*14-2 DHS Sexual Abuse Prevention and Response (pg. 7, sec. B2f)* states, "CoreCivic shall ensure that criminal background records checks are completed at least every five (5) years for current employees and contractors who may have contact with detainees (115.17 (c))." During the onsite audit, the auditor conducted 10 random employee file reviews and found that all 10 employees received a completed initial criminal background investigation. Eight of the 10 employees had not been hired long enough to receive a five-year subsequent background investigation. However, two employees who have been employed with the facility for more than five years had received a subsequent background investigation. Review of documentation provided by ICE's PSU confirmed that the three randomly selected ICE employees background checks were performed prior to them reporting to work. Documentation also confirmed the due dates for the five-year background rechecks. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(d) In accordance with the PAQ submitted during the pre-onsite audit, the agency or facility perform a background investigation before enlisting the services of any contractor who may have contact with detainees. Policy*14-2 DHS Sexual Abuse Prevention and Response (pg. 7, sec. B2d)* 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 (115.17(d))." The HR staff person also reported that upon request by the agency, LPC submits for the agency's approval written documentation showing the detailed elements of the facility's background check for each contractor and the facility's conclusions. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(e) During the pre-onsite audit, the PAQ indicated that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate. Policy*14-2 DHS Sexual Abuse Prevention and Response (pg. 7, sec. B2b)* 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 (115.17(e)." The HR staff person interviewed confirmed such ommissions would be grounds for termination or withdrawl of an offer of employment. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(f) During the pre-onsite audit, Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that unless prohibited by law, the agency 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. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

§115.18 - Upgrades to facilities and technologies.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) During the pre-onsite audit, the PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 19, sec. I1)* stated that when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility or agency, as appropriate, shall consider the effect of the design, acquisition, expansion, or modification upon their ability to protect detainees from sexual abuse. The above policy also stated that this consideration shall be documented. The facility reported that a laundry room was added in January 2017. The auditor reviewed documentation demonstrating that the facility took the previous PREA audit recommendations into consideration when implementing video cameras in the new laundry room to eliminate blind spots. The auditor observed that the new laundry room had addressed all blind spots by installing updated cameras. The Warden also reported that the facility did not recently move to a newly designed or acquired facility since the last PREA audit. However, the Warden advised that the facility had installed a new laundry building since that time. He reported that the facility took all of the previous auditor's report concerns into consideration to include adding cameras to previously identified blindspost areas throughout the facility. Given the provided information, the facility has exemplified that it considered the safety and security of its detainees as well as the previous auditor's concerns during the implementation of the new laundry building and camera system. Therefore, the auditor determined that the facility has met beyond the requirements of this standard provision.

(b) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 19, sec. I1)* stated, "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in an immigration detention facility, the facility or agency, as appropriate, shall consider how such technology may enhance their ability to protect detainees from sexual abuse." In accordance with the PAQ, the facility reported that its camera system was initially installed in 2007. However, new cameras were installed in the new laundry room which was built in January 2017. An *Application for Alteration/Addition* dated 05/06/19 was submitted to upgrade the camera system in accordance with PREA guidelines and approved by the Warden and Managing Director on 05/06/19 and the Facilities Management Director on 05/14/19. During the onsite audit, the Warden stated that a new camera system was installed since the last PREA audit. He stated that they made sure that all the previous auditor's report concerns related to blindsposts throughout the facility were taken into consideration during the implementation of the new camera system. During the onsite tour, the auditor observed the new video camera system from the control center and was advised that some of the cameras had rotational capabilities while all had zooming capabilities. The auditor also viewed that the quality of the camera footage was crystal clear. The auditor reviewed the previous audit report prior to entering the facility and found that the previous auditor's concerns were taken into consideration during the implementation of the immaculate new camera system. All previous blind spots have been abated. Given the provided information, the facility has exemplified that it considered the safety and security of its detainees as well as the previous auditor's concerns during the implementation of the new laundry building and camera system. Therefore, the auditor has determined that the facility met beyond the requirements of this standard provision.

§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) The PAQ indicated that to the extent the agency or facility is responsible for investigating allegations of sexual abuse involving detainees, it shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 35, sec. O3a.)* 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 PAQ also indicated that LPC does not house juvenile detainees. Therefore, coordinating with DHS to ensure such protocols are developmentally appropriate for juveniles is not applicable. However, Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 35, sec. O3b.)* states that the protocol shall be developmentally appropriate for juveniles, where applicable. LPC and LPD entered into a memorandum of understanding (MOU) on 03/22/19 which supports the requirements of this standard provision. PREA allegations may also be investigated through OPR or the DHS OIG. Agency policy 11062.2, SAAPI Diretive, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS OIG, OPR, or local law enforcement agency, the AFOD would assign an administrative investigation to be conducted. During the onsite audit, the auditor reviewed the one closed investigative file during this audit period and found it was referred to ICE OPR and determined to be unsubstantiated after investigation by the LPC investigator. The PSA Compliance Manager stated that LPC uses uniform evidence protocols developed in coordination with DHS which includes objectivity of investigations and that they are conducted in a timely manner. The PSA Compliance Manager stated that the facility has a uniform evidence protocol, for instance, the police department, medical, and ICE are notified. He further stated that the facility will make sure every document is completed immediately. He presented the auditor with an unfilled checklist, which he stated he uses to ensure all documents are completed and all individuals are contacted. He stated that the specialized investigation trained captains initiate the investigation by interviewing the victim, alleged

perpetrators, and witnesses. The PSA Compliance Manager stated that the Rape Crisis Center of San Antonio is used to provide seven days per week, 24 hours a day hotline to receive reports of sexual abuse, confidentially and anonymously and to provide crisis intervention in addition to detainees receiving sexual assault examinations at Doctors Hospital. He confirmed that the facility has an MOU with the above hospital. The PSA Compliance Manager also reported that medical would coordinate victim services. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(b) During the pre-onsite audit, the PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 35-36, sec. O3d.)* indicated, "LPC shall establish procedures to make available, to the full extent possible, outside victim services following incidents of sexual abuse; the facility shall attempt to make available to the victim a victim advocate from a rape crisis center." According to Policy *14-2 DHS Sexual Abuse Prevention and Response,* the Rape Crisis Center of San Antonio provides victim advocacy services to detainees housed at LPC. An MOU between the facility and the Rape Crisis Center of San Antonio dated 03/02/15 provides a 24-hour hotline where detainees may report sexual victimization anonymously, confidentially, as well as receive crisis intervention. The MOU between LPC and Doctors Hospital of Laredo dated 05/01/21 facilitates advocacy services to detainees as needed. During the onsite audit interview with the PSA Coordinator, the auditor was informed that there was no victims sent to the medical center during this audit review period. He advised that if detainee victims are offered but did not want to receive such services and each refusal documented within the investigative files. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(c) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* state that where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility shall arrange for an alleged victim detainee to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel. The MOU between LPC and Doctors Hospital of Laredo dated 05/01/21 addresses services to meet the requirements of this standard. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(d) During the pre-onsite audit, the PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* state that as requested by a victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. The MOU between LPC and Doctors Hospital of Laredo dated 05/01/21 supports the requirements of this standard. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(e) In accordance with the PAQ submitted during the pre-onsite audit, LPD is responsible for investigating allegations of sexual abuse, and LPC requests that the investigating agency follow the requirements of paragraphs (a) through (d) of this section. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 35-36, sec. O3)* 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 investigation 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 (115.21 (e))." The MOU between LPC and LPD dated 03/22/19 indicates that LPD is responsible for investigating allegations of sexual abuse and that LPD follows the requirements of this standard. During the onsite audit, the PSA Compliance Manager reported that LPD conducts criminal investigations for the facility and that LPD follows the facility's evidence protocol. Also during the tour of the facility, medical staff stated if there was an allegation of sexual abuse, they would send the detainee to the hospital to have a sexual assault examination conducted. They reported that the facility has an MOU with Doctors Hospital Center. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

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

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

Notes:

(a) During the pre-onsite audit, the PAQ indicated that the facility has a protocol to ensure that each allegation of sexual abuse is investigated by the agency or the facility or referred to an appropriate investigative authority. The PAQ indicated that an administrative and criminal investigation is completed for all allegations of sexual abuse. In accordance with Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 32, sec. O.)*, "the Facility Administrator will ensure that an administrative investigation is completed for all allegations of sexual abuse or assault. If there is potential criminal behavior, the Facility Administrator will ensure a referral for criminal investigation is sent to a law enforcement agency with legal authority. All sexual abuse allegations must be conducted by qualified investigators." All investigations are to be reported to the Joint Intake Center (JIC) who assesses allegations to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by OPR, they will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation. The AFOD would assign an administrative investigation to be completed. All investigations are closed with a report of investigation. The agency's policy

11062.2 outlines the evidence and investigation protocols. During the training manager's onsite interview, the auditor reviewed two random training files for staff assigned to investigate PREA related allegations and confirmed that both received specialized training to conduct such investigations. During the onsite interview with the PSA Compliance Manager, the auditor was informed that the facility has a protocol to ensure each allegation of sexual abuse is investigated by the agency, facility, or LPD. The PSA Compliance Manager informed the auditor that medical would follow up immediately once a detainee victim is returned from the hospital. The Warden reported, during his onsite interview, that the facility protocol includes them contacting the regional supervisor for CoreCivic, local law enforcement, and ICE. The Warden further stated that the incidents are referred to the PREA administrative investigators (six shift captains) to investigate. The auditor conducted one investigative file review of a detainee-on-detainee sexual abuse allegation occurring within this audit period.The auditor found that an administrative investigation was conducted on the allegation. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(b) The PAQ indicated that LPC investigative protocol includes a description of responsibilities of the agency, the facility, and any other investigating entities. Also, Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 33, sec. Oc1.)* indicated, "a detailed description of the facility's administrative investigative responsibilities." The policy also stated that all reports and referrals of allegations are retained for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five years. The *Detainee Assistance Alternatives* flyer posted in English and Spanish on the housing unit bulletin boards provides educational information to detainees on sexual abuse victimization, crisis intervention, agency and facility responsibilities. The MOU between LPC and the LPD, dated 03/22/19, demonstrates the facility and LPD's investigative protocols and supports the requirements of this provision. During the onsite interview with the PSA Compliance Manager, the auditor was informed that the facility would provide ICE with supporting information that it collected to assist with ICE's investigation of sexual abuse. The Warden informed the auditor during his onsite interview that the facility would complete its investigation and provide collected information to local law enforcement and ICE to assist with their investigations. The Warden recalled an incident of sexual abuse having taken place in LPC during this audit period and advised that the shift captain made immediate notification to LPD, ICE, and the CoreCivic regional supervisor. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(c) The Shift Supervisor and Quality Assurance Manager indicated through the PAQ that LPC's investigative protocols are posted on facility's website. The auditor accessed the facility's website at https://www.corecivic.com/facilities/laredo-processing-center and was able to view the facility's protocols. The ICE website, www.ice.gov/prea, includes information on the agency's PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE National Detainee Handbook, ICE PREA poster, and ICE PREA pamphlet. 115.22(d)(e)(f). Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(d) The Shift Supervisor and Quality Assurance Manager indicated through the PAQ that LPC's protocol ensures all allegations are promptly reported to the agency as described in paragraphs (e) and (f) of this section. LPC also reported through the PAQ that its protocol ensures that all allegations are promptly referred for investigation to an appropriate law enforcement agency with legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. The PAQ indicated that LPC received two reports of sexual abuse that occurred in its facility during this audit period however, one allegation reported during the audit period by the facility was deemed non-PREA by the agency; and as such, the Auditor did not include in their sample case file review for compliance determination. The auditor reviewed LPC's *Sexual Abuse Incident Checklist* and observed that within the facility's protocol, the shift supervisor, the Warden, local law enforcement agency, and the ADO are notified immediately on sexual abuse allegations. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(e) LPC reported through the PAQ that it ensures that the incident is promptly reported to the appropriate ICE FOD when a detainee, prisoner, inmate, or resident is alleged to be the perpetrator of sexual abuse at the facility. LPC also reported that if the sexual abuse allegation is potentially criminal, the allegation is referred to an appropriate law enforcement agency that has jurisdiction for investigation. During the onsite audit, the auditor conducted one investigative file review of a detainee-on-detainee sexual abuse allegation occurring within this audit period. The auditor found that the facility notified ICE ERO, ICE OPR, DHS OIG, and the JIC. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

(f) The PAQ submitted during the pre-onsite audit indicates that 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 appropriate ICE Field Office Director and the local government entity or contractor that owns or operates the facility. Also, The PAQ indicated that if the incident is potentially criminal, it ensures that the incident is promptly referred to an appropriate law enforcement agency having jurisdiction for investigation. The PAQ indicated that LPC received two reports of sexual abuse that occurred in its facility during this audit period however, one allegation reported during the audit period by the facility was deemed non-PREA by the agency; and as such, the Auditor did not include in their sample case file review for compliance determination. During the onsite audit, the auditor conducted one detainee-on-detainee investigative file review of sexual abuse allegation occurring within this audit period which is not relevant to this particular component. An interview with the Warden indicated that the facility would notify ICE ERO, ICE OPR, DHS OIG, and the JIC if a staff member, contractor or volunteer were identified as the alleged perpetrator of sexual abuse. Given the information provided, the auditor determined that the facility meets the requirements of this standard provision.

§115.31 - Staff training.

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

(a) During the pre-onsite audit, the PAQ indicated that all employees who may have contact with detainees and facility staff have been trained to fulfill their responsibilities under this standard, including training on: (1) The agency and facility's zero-tolerance policies for all forms of sexual abuse; (2) The right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; (3) Definitions and examples of prohibited and illegal sexual behavior; (4) Recognition of situations where sexual abuse may occur (5) Recognition of physical, behavioral, and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; (6) How to avoid inappropriate relationships with detainees; (7) How to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; (8) Procedures for reporting knowledge or suspicion of sexual abuse; and (9) The requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. Policy *14-2 DHS Sexual Abuse Prevention and Response (pg. 6, sec. B3.)* 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..." Such responsibilities are specifically described in this policy. The facility training curriculum supports the requirements of this standard provision. The auditor reviewed and confirmed that the facility training curriculum for all employees addresses the requirements of this standard provision. The training manager reported that all staff who have contact with immigration detainees receive training on sexual abuse prevention and response, reporting mechanisms, multiple ways for detainee reporting which includes the OIG hotline, a family member, and any staff, contractor, or volunteer. He also stated that officers are provided with PREA cards in which they may reference their first responder responsibilities. The auditor confirmed that the referenced PREA cards indicated first responder duties, the PSA Compliance Manager, health and mental services, shift captain, and victim services coordinator's information. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(b)(c) The PAQ indicated that all employees who may have contact with detainees have been trained within one year of May 6, 2014, or the date the facility's contract was modified to incorporate DHS PREA. Also, the PAQ indicated that refresher information is provided every two years. In accordance with Policy *14-2 DHS Sexual Abuse Prevention and Response,* all new and current facility staff shall receive such training as described in paragraph (a) and receive annual refresher or in-service training thereafter. The PAQ indicated that it documents that staff who may have contact with detainees have completed the training. Thirty-eight samples of in-service training rosters were provided to demonstrate that a total of 110 employees received PREA training pursuant to this standard. During the onsite audit, the auditor conducted 10 random employee file reviews. Seven of the 10 employee file reviews indicated that staff had received PREA training within one year of May 6, 2014, or the DHS PREA incorporation date. Nine of the 10 employee file reviews indicated that such training was documented. There was 1 out of the 10 employee file reviews that the auditor was unable to locate any training within two years, although she was scheduled to receive such training; therefore, the facility ensured the employee completed PREA training on 12/08/21 and provided the auditors with signed documentation of acknowledging completion. Nine of the 10 file reviews indicated that staff received PREA refresher training. The auditor also reviewed two ICE staff training records and confirmed they had received PREA pre-service training and annual refresher training. During the onsite audit interview, the training manager stated that PREA refresher training is provided to all employees on an annual basis. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

§115.32 - Other training.

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

(a) The PAQ submitted during the pre-onsite audit indicated that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the agency and facility's sexual abuse prevention, detection, intervention and response policies and procedures. AFOD memorandum dated 09/24/21 stated that due to COVID-19 pandemic, there has been no training of new volunteers since March 2020. Volunteers and contractors' training curriculum meets the requirements of this standard. The facility reported that it had 30 contractors. During the onsite audit, three contractors were interviewed by the auditor. All three stated that they have contact with immigration detainees and have been trained on sexual abuse prevention and response. They also reported that they receive refresher training annually through in-person and/or online formats. The facility provided the initial training records for 14 contractors. Thirteen of the 14 contractors had received such annual refresher training. While onsite, the facility ensured that the other contractor completed such training and provided the auditor with documentation confirming completion. The auditor conducted one volunteer interview while onsite. The volunteer stated that she received PREA training during orientation and the auditor viewed the initial training record confirming compliance. The volunteer also stated that she is familiar with detainee PREA education and resources available to detainees. In addition, the volunteer explained how she would immediately report a PREA allegation if received. Given the information provided, the auditor has determined that the facility meets the requirements of the standard provision.

(b) The PAQ indicated that the level and type of training provided to volunteers and other contractors shall be based on the services they provide and level of contact they have with detainees. A review of the PAQ also indicated that all volunteers and other contractors who have contact with detainees are notified of the agency and the facility's zero-tolerance policies regarding sexual abuse and informed on how to report such incidents. During the onsite audit, the training manager was interviewed and advised that all contractors and volunteers receive two hours of in-person PREA training. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(c) The PAQ indicated that the facility maintains written confirmation that volunteers and other contractors who have contact with immigration facility detainees have completed the training. A medical contractor in-service training roster was provided to demonstrate that six medical contractors completed such training. During the onsite audit, the training manager stated that contractors and volunteers also receive annual PREA refresher training. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

§115.33 - Detainee education.

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

Notes:

(a) Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated, "LPC's detainee orientation program notifies and informs detainees about the agency and the facility's zero-tolerance policies for all forms of sexual abuse and includes (at a minimum) instruction on: (1) Prevention and intervention strategies; (2) Definitions and examples of detainee-on detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; (3) Explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of contact line officer (e.g., the compliance manager or a mental health specialist), the DHS Office of Inspector General, and the Joint Intake Center; (4) Information about self-protection and indicators of sexual abuse; (5) Prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and (6) The right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." The auditor reviewed a transcript of the video educating detainees on the above standard requirements during the intake process. The auditor observed this video playing in English and Spanish in the intake processing area during the onsite audit tour and found it covered all requirements of this provision. During the onsite audit, the auditors conducted 10 detainee file reviews. According to the file reviews, all 10 detainees were LEP. All 10 file reviews indicated that the detainees received the ICE National Detainee Handbook and the facility's Detainee Handbook. The auditor also interviewed three LEP detainees during the onsite audit whose preferred language was Spanish. The three targeted LEP detainees stated that they were able to communicate with staff during the intake process and that they received information about sexual abuse, its definitions, and how to stay free from sexual abuse. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(b)(c) During the pre-onsite audit, the PAQ indicated that detainees receive notification, orientation, and instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. The intake staff indicated to the Auditor that when intake staff is confronted with a detainee that may be hearing impaired or deaf, most CCCC orientation information is provided to them in writing or if that is not successful, information would be provided through the use of the text telephone (TTY). When staff encounters a detainee who is blind or with limited sight the staff member would attempt to provide individualized service to the detainee to include reading information if needed. Also, the PAQ indicated that LPC maintains documentation of detainee participation in the intake process orientation. A copy of the *Language Preference* form used during the intake process to acknowledge detainees' participation in the intake orientation process was provided to the auditor. During the onsite audit, the auditors conducted 13 detainee file reviews. All 13 detainees were LEP, and their file reviews indicated that they all received PREA information in appropriate formats during the intake process and their orientation were documented. Also, all 10 file reviews indicated that the detainees received the ICE National Detainee Handbook and the facility's Detainee Handbook. The ICE National Detainee Handbook is available in 14 of the 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 onsite tour, the auditor viewed the DHS-prescribed Sexual Abuse Awareness Information pamphlet is available in English and Spanish only at LPC. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(d)(e)(f) A review of the PAQ indicated that the DHS-prescribed sexual assault awareness notice, the name of the Prevention of Sexual Abuse Compliance Manager, and the name of local organizations that can assist detainees who have been victims of sexual abuse are posted on all housing unit bulletin boards. Also, the PAQ indicated that information about reporting sexual abuse is included in the Detainee Handbook and is available to all detainees. The DHS-prescribed sexual assault awareness notice was provided in English and Spanish, and the auditor observed this notice posted on the bulletin boards in the detainee housing units. The ICE National Detainee Handbook and the facility's Detainee Handbook included information on reporting sexual abuse. During the onsite audit, the auditors conducted 10 detainee file reviews which indicated that all 10 detainees received both ICE and the facility's Detainee Handbook and each confirmed their knowledge of the posters and the required reporting information. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

§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) During the pre-onsite audit, the PAQ indicated that LPC provides specialized training on sexual abuse and effective cross-agency coordination to its investigators who conduct sexual abuse investigations. The facility reported that all sexual abuse investigations are conducted by qualified investigators. Also, the PAQ indicated that written documentation verifying specialized training pursuant to this section is maintained. Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that such training includes interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral. LPC's Investigation Protocols curriculum was reviewed by the auditor. During the onsite audit, the Warden, the training manager, the PSA Compliance Manager, and random staff reported that supervisors and the recreation

supervisor has authority to conduct PREA related interviews. During the training manager's interview, the auditor reviewed two random training files for staff assigned investigators and confirmed that both received specialized training to conduct PREA investigations. The auditor reviewed one detainee-on-detainee investigative case while onsite and confirmed the investigation was completed by a specialized trained facility investigatior. 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 Auditor reviewed the ICE OPR Investigation Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The Auditor reviewed the agency provided rosters of trained investigators on SharePoint and determined the documentation was in accordance with the training requirements of this standard. Given the information provided, the auditor has determined that the facility meets the requirements of this standard.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b) These subparts of the standard do not apply to LPC as the facility medical department is operated by CoreCivic.

(c) The facility PAQ indicated that the required training includes how to detect and assess signs of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, how and to whom to report allegations or suspicions of sexual abuse, and how to preserve physical evidence of sexual abuse. Policy *14-2 DHS Sexual Abuse Prevention and Response* outlines such training requirements indicated in this standard. AFOD memorandum dated 09/24/21 stated that there are no ICE Health Services Corps/U.S. Public Health Service (IHSC/USPHS) at LPC. The auditor reviewed the specialized training curriculum for medical and mental health practitioners and found that it meets the requirements of this standard. During the onsite audit, the auditor conducted an interview with the Training Manager and was advised that in addition to the PREA training received by all employees, contractors, and volunteers, medical staff also receive specialized PREA training for medical and mental health practitioners. Such training is provided through e-learning. The auditor also reviewed a training roster indicating and acknowledging that 13 medical staff had received specialized training and all within the past 12 months. Although sexual assault examinations are not provided at the facility, LPC has proven that it requires its medical and mental health staff to complete specialized PREA training. The facility documents and retains such training. The facility has gone beyond this standard's requirements. Therefore, the auditor has determined that the facility exceeds the requirements of this standard.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that it assesses all detainees upon intake to identify those likely to be sexual aggressors or sexual abuse victims and house such detainees to prevent sexual abuse. Each detainee is kept separately from the general population until the detainee is classified and housed accordingly. The PAQ also indicated that the initial classification process and initial housing assignment is completed within 12 hours of admission to the facility. During the onsite audit, the auditors conducted 10 detainee file reviews and found that all 10 detainees were assessed for risk of victimization and risk of abusiveness within 12 hours of admission to the facility. The auditor conducted a tour of the facility to include the intake processing area and the PSA Compliance Mangager advised that detainees received initial classification and PREA assessment within 12 hours of intake and before being assigned to a housing unit. Intake staff reported that detainees must complete the intake process before they are housed with other detainees. The auditor interviewed 10 random detainees who all reported that they spent a significant amount of time in intake. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(c)(d) A review of the updated PAQ indicated that the initial screening includes, if information is available, whether the detainee has a mental, physical, or developmental disability, the detainee's age, the physical build and appearance of the detainee, the detainee's previous history of incarceration or detention, the nature of the detainee's criminal history, the detainee's previous convictions for sex offenses against an adult or child, the detainee's self-identification as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, the detainee's history of sexual victimization, and the detainee's own concerns about his or her physical safety. The auditor viewed and confirmed that the criteria in this standard are considered on the Initial Custody Classification and Sexual Abuse Screening Tool forms which are completed during intake. The auditor was not informed of any detainees being classified or undergoing the intake process while onsite; therefore, the auditor asked that the facility intake staff demonstrate the detainee intake process and observed staff perfoming each facility responsibility related to this provision. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(e)(f)(g) During the pre-onsite audit, the facility reported that each detainee's risk of victimization or abusiveness is reassessed between 60 and 90 days from the initial assessment and at any other time when warranted. The two randomly selected investigative case files reviewed confirmed a vulnerability reassessment was completed within 12 hours of the allegation in each case and reassessed for victimization or abusiveness between 60 and 90 days from the incident as well. The PAQ indicated that detainees are

not disciplined for refusing to answer or for not disclosing complete information during such assessments. Policy *14-2 DHS Sexual Abuse Prevention and Response* and the PAQ indicated that the facility implements appropriate controls on the dissemination within facility of responses to questions asked pursuant to this standard. The PSA Compliance Manager stated that staff is provided ongoing training to adhere to the facility's confidentiality standards. The facility provided a sample of a 60-90 day detainee screening. During the onsite audit tour, the PSA Compliance Manager informed the auditor that most detainees do not stay in the facility long enough to receive a reassessment. The auditors also conducted 10 detainee file reviews onsite and found that four reassessments were completed on detainees who had been in the facility for 60 days or longer during this audit period. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

§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) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that the facility uses information from the risk assessment to provide housing assignment, recreation and other activities of detainees. Such determinations are made individually to ensure the safety of each detainee. During the onsite audit, the intake staff reported that information from the risk assessment is used to make appropriate housing determinations. The intake staff member confirmed assignments are made for work and housing based on each individual detainee's risk assessment. The instructions for completion of the document informs the staff member, conducting the risk assessment, that it is important that any PREA classification, whether it indicates the potential for being at risk of victimization or the potential of being sexual abusive be noted to provide the correct initial housing for placement. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(b)(c) A review of the updated PAQ indicated that when making assessment and housing decisions for a transgender or intersex detainee, the facility considers the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The PAQ indicated that LPC consults a medical or mental health professional as soon as practicable on this assessment. Also, the PAQ indicated that LPC does not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee and that a detainee's self-identification of his/her gender and self-assessment of safety needs are always taken into consideration. The PAQ indicated that placement of a transgender or intersex detainee is consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee is reassessed at least twice each year to review any threats to safety experienced by the detainee. The PSA Compliance Manager reported that transgender and intersex detainees are given the opportunity to shower separately from other detainees. AFOD memorandum dated 10/11/21 stated that there were no transgender or intersex detainees or reassessments of such detainees during this audit period. During the onsite audit tour, the PSA Compliance Manager informed the auditor that there were no transgender or intersex detainees in the facility. As such, the auditor was unable to observe any transgender/intersex assessments, housing decisions or conduct file reviews. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

§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)(d) A review of the updated PAQ and interview with the PSA Compliance Manager indicated that LPC develops and follows written procedures consistent with the standards in this subpart governing the management of its administrative segregation unit. The PAQ indicated that the procedures are developed in consultation with the ERO having jurisdiction for the facility, and "must document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault." Policy *14-2 DHS Sexual Abuse Prevention and Response* states, "Detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate." This policy also states that supervisory staff shall conduct a review within 72 hours of the detainee's placement in segregation to determine if it is still warranted and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in Administrative Segregation and every week thereafter for the first thirty (30) days and every ten (10) days thereafter." The Warden confirmed that any placement of a vulnerable detainee in segregation would require, as stipulated in policy, the reviews and the notification to the FOD within 72 hours. The Warden also reported that placement of vulnerable detainees in administrative segregation for protective custody shall provide those detainees access to programs, visitation, counsel and other services available to the general population to the maximum extent practicable. AFOD memorandum dated 10/11/21 stated that there were no detainees housed in protective custody or administrative segregation during this audit period. During the onsite audit, the auditors conducted 10 random detainee file reviews. Of the 10 file reviews, there were no indications of a detainee being housed in protective custody. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(e) A review of the updated PAQ and interview with the PSA Compliance Manager indicated that the facility notifies the appropriate ICE Field Office Director no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault. The PAQ also indicated that upon receiving such notification, the ICE Field Office Director shall review the placement and consider whether continued placement in administrative segregation is warranted, whether any alternatives are available and appropriate, such as placing the detainee in a less restrictive housing option at another facility or other appropriate custodial options, and whether the placement is only as a last resort and when no other viable housing options exist. Policy *14-2 DHS Sexual Abuse Prevention and Response* stated that the ICE Field Office Director would be contacted if appropriate custodial options are not available at the facility when housing detainees considered to be at risk of

victimization. AFOD memorandum dated 10/11/21 indicated that if an incident would have occurred during this audit period where a detainee is placed in protective custody or administrative segregation, the facility Warden would notify the AFOD through email and phone call within 72 hours. During the onsite audit, the auditors conducted 10 random detainee file reviews. Of the 10 file reviews, there were no indication of a detainee being housed in administrative segregation. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

§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) During the pre-onsite audit, the PAQ indicated that ICE and the facility develop policies and procedures to ensure that detainees have multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. According to the PAQ, LPC and ICE shall also provide instructions on how detainees may contact their consular official, the DHS OIG or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents. The PAQ also indicated that the agency provides, and the facility informs the detainees of at least one way to report sexual abuse to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous upon request. The auditor interviewed 10 random detainees and each stated they were aware of multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse. LPC policies and procedures include provisions for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. DHS and LPC's phone log provide instructions on how detainees may contact their consular, the DHS OIG, and the Corecivic twenty-four hour ethics line for confidential and anonymous reporting of sexual abuse. The DHS OIG information was provided, and the auditor observed this information posted on the housing unit bulletin boards. During the onsite audit, the auditors conducted four specialized staff interviews, three non-security contractor interviews, one volunteer interview, two non-security first responder interviews, and three security staff/line supervisor interviews which totals 13 staff interviews. When asked, four of the staff members stated that detainees may report verbally, in writing, anonymously or through a third-party. During the onsite interview with the PSA Compliance Manager, the auditor was informed that detainees may report sexual abuse by submitting a confidential letter to the Facility Administrator or any other employee, through the OIG hotline, a family member, and anonymously report any pressure, threat or instance of sexual violence/misconduct directly to the DHS OIG at 1-800-323-8603 and that detainees are made aware of multiple ways to report during orientation. The facility reported that during this audit period, there were two sexual abuse cases reported; one allegation reported during the audit period by the facility was deemed non-PREA by the agency; and as such, the Auditor did not include in their sample case file review for compliance determination. The PSA Compliance Manager stated that the sexual abuse reports were made to the captains and the Auditor's review of one closed sexual abuse case file further confirmed this. Given the information provided, the auditor has determined that the facility and agency meet the requirements of this standard.

§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) The facility and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated the facility permits a "detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint." LPC also reported that it does not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. In addition, the facility implemented written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. AFOD memorandum dated 10/11/21 stated that the facility did not receive a sexual abuse grievance or appeal during this audit period. The facility's Detainee Handbook indicates that formal grievances related to sexual abuse may be filed at any time. According to the ICE National Detainee Handbook, LPC does not impose a time limit for submitting such grievance. When asked, five staff members reported that they would accept a sexual abuse report made through the grievance system and would ensure medical emergencies are referred to the medical department immediately. The auditor conducted one investigative file review of a detainee-on-detainee sexual abuse allegation occurring within this audit period. During the investigative file review, there were no indications of a sexual abuse or sexual misconduct allegation stemming from a grievance. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(e)(f) Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that the facility issues a decision on the grievance within five days of receipt and responds to an appeal of the grievance decision within 30 days. The PAQ indicated that LPC sends all grievances related to sexual abuse and the facility's decision with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process. A detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives to assist with preparing a grievance, and staff shall take reasonable steps to expedite requests for assistance from these other parties. The facility's Detainee Handbook indicated that a detainee may receive assistance from staff or another detainee when necessary to communicate the problem on a grievance form. AFOD memorandum dated 10/11/21 stated that the facility did not receive a sexual abuse grievance or appeal during this audit period. During the onsite audit interview with the grievance coordinator, the auditor was informed that the facility received a total of five grievances during this audit period. Of the five grievances, there were no grievances of sexual abuse received. During the investigative file reviews, there was no indication of a sexual abuse or sexual misconduct allegation stemming from a grievance. Given the provided information, the auditor has determined that the facility meets the requirements of this standard provision.

§115.53 - Detainee access to outside confidential support services.

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

(a)(b)(c) During the pre-onsite audit, the PAQ indicated that LPC utilizes available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse perpetrators to most appropriately address victims' needs. The facility maintains or attempts to enter into memoranda of understanding or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime. Policy *14-2 DHS Sexual Abuse Prevention and Response* indicates the facility's established procedures to include the San Antonio Rape Crisis Center in its sexual abuse prevention and intervention protocols. According to LPC's reported information and Policy *14-2 DHS Sexual Abuse Prevention and Response*, the facility makes available to detainees, information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). While onsite, the auditor observed that this information was made available to detainees in 14 different languages on the tablets and through the ICE National Detainee Handbook. The auditor also confirmed this information is provided to detainees through the facility's Detainee Handbook. The auditor observed such information posted on the detainee housing unit bulletin boards. The auditor also viewed the PREA informational video being played (English and Spanish) in the intake area and in one of the housing units during the onsite audit tour. The auditor reviewed the MOU established between the facility and the San Antonio Rape Crisis Center and found that the standard required services are indicated. Of the 10 random detainee interviews conducted onsite, eight detainees recalled seeing or hearing about organizations for supporting victims of sexual abuse. The Auditor's review of two investigative files noted the alleged victims were provided contact information for the Rape Crisis Center of San Antonio. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

(d) During the pre-onsite audit, the PAQ indicated that detainees are informed, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The auditor observed DHS OIG, ICE and facility PREA notices posted on the detainee housing unit bulletin boards informing detainees of the extent to which such communications will be monitored. During the onsite audit interview with the PSA Compliance Manager, the auditor was informed that detainees are informed of the extent to which their communications will be monitored usually through phone verification in medical and housing unit red zone areas (privacy). The PSA Compliance Manager stated that the detainees dial the number nine to access such services through the phones on their housing units. Given the information provided, the auditor has determined that the facility meets the requirements of this standard provision.

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

The PAQ indicated that the facility has established a method to receive third-party reports of sexual abuse and publicly informs on how to report sexual abuse on behalf of a detainee. Third parties may report sexual abuse on behalf of a detainee through the ICE Detention Reporting and Information Line and while onsite the auditor successfully conducted a test to ensure third-party reporting was accepted. According to Policy *14-2 DHS Sexual Abuse Prevention and Response* the facility has multiple methods to receive third party reports of sexual abuse to include the JIC Toll-Free Hotline number 877-246-8653. The auditor observed this information posted on the bulletin boards in the detainee housing units during the onsite audit tour. A review of both the ICE web page (https://www.ice.gov) and CoreCivic web page (http://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 detainees as well. Also, the auditor confirmed this information in the ICE National and facility's Detainee Handbook. Throughout 13 staff interviews and 10 random detainee interviews, the auditor was informed that the facility has methods for third party reporting of sexual abuse. The PSA Compliance Manager reported they had zero incidents of sexual abuse reported by a third during the adjusted audit cycle and the Auditor's review of one closed case confirmed this report. Given the provided information, the auditor has determined that the facility meets the requirements of this standard.

§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) During the pre-onsite audit, the PAQ indicated that the agency and facility require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in the facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff must immediately follow reporting requirements set forth in the agency and facility's written policies and procedures. The PSA Compliance Manager and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff, or to make medical treatment, investigation, law enforcement, or other security and management decisions. The 14-2-DHS policy was approved by the AFOD. During the onsite audit interviews with specialized and random staff, the auditor was informed that staff are required to report PREA related incidents immediately to either the shift captain, PSA Compliance Manager, and/or Warden. Given the above information provided, the auditor deems that the facility meets the requirements of this standard.

(d) LPC does not house juveniles; and therefore, the auditor has determined this provision to be non-applicable

§115.62 - Protection duties.

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

The PAQ indicated if an agency employee or the facility staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee. The Auditor questioned the Warden, PSA Compliance Manager, and random staff about the handling of detainees they believed may be at substantial risk of imminent sexual abuse. Each staff member interviewed indicated that detainee placement in the medical unit would be the likely immediate response by the facility to eliminate the threat. The Warden indicated that movement from the facility would be considered after the situation was evaluated.There were no reports of a detainee being subjected to a substantial risk of imminent sexual abuse. As indicated in the summary, the Auditor interviewed a total of 15 detainees during the onsite audit; of the 15, no detainee reported that she was in imminent danger of sexual abuse. Given the information provided, the auditor has determined that the facility meets the requirements of this standard.

§115.63 - Report 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) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that upon receiving an allegation that a detainee was sexually abused while confined at another facility, LPC notifies the appropriate office of the agency or the administrator of the facility where the abuse occurred within 72 hours after receiving such allegation. LPC reported through the PAQ that the facility documents this notification. The PAQ also indicated, "If LPC receives an allegation of sexual abuse from another confinement facility about a detainee who was previously detained at the facility, LPC reports the allegation to the ICE Field Office Director." AFOD memorandum dated 10/11/21 stated that there were no instances of receiving a report of sexual abuse that occurred in another facility during this audit period, and if the facility received such report, the facility PSA Compliance Manager would call the other facility administrator and make notification. During the onsite audit, the auditor conducted an interview with the Warden and was advised that if the facility received an allegation that a detainee was sexually abused in another facility, the captains would notify the PSA Compliance Manager, the Warden, and the ICE San Antonio Field Office as well as LPD. He also stated that Field Office would make this notification to other facility. The Warden stated that there were no such reports received during this audit period and the one investigation file review conducted by the auditor confirmed the case was not related to another confinement facility. In addition, the Warden stated that if LPC received a report from another facility administrator, he would have it investigated by a designated facility investigator who has received specialized investigative training on sexual abuse in a confinement facility. Given the information provided, the auditor determined that the facility meets the requirements of this 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)(b) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or his or her supervisor, shall be required to: (1) Separate the alleged victim and abuser, (2) Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence, (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, and (4) If the sexual abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including the above actions. If the first staff responder is not a security member, the responder is required to request that the alleged victim not take any of the above actions that could destroy physical evidence and notify security staff." During the onsite audit, two non-security staff first responders were interviewed by the auditor. They reported that upon notification of a detainee sexual abuse incident, the following steps were taken: (1) Preserve and protect physical evidence on the alleged victim by requesting the victim to refrain from showering, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, and (2) Law enforcement notification. In addition, one of the non-security staff stated that Doctors Medical Health was contacted for a SANE. The other non-security staff additionally stated that the report was made immediately. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

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

(a)(b) A review of the updated PAQ indicated that LPC has a written institutional plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated such coordinated actions taken by staff first responders. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

(c)(d) The PAQ indicated that if a victim of sexual abuse is transferred between facilities covered by subpart A or B, or a DHS immigration detention facility not covered by paragraph (c), it shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. An auditor review of one sexual abuse allegation case file found the victim was not transferred to or from the facility. During the onsite audit, the Warden stated that details about the victim, perpetrator, and incident are provided to the other facility upon transfer. Given the information provided, the auditor has determined that the facility meets the requirements of this standard.

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

During the pre-onsite audit review, the PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. The Warden stated that the facility protects detainee victims from alleged abusers. He further stated that staff, volunteers, or contractors would be separated and removed to ensure there is no contact with the detainee victim. During this audit period, there were no closed cases meeting the criteria of this standard for the auditor to review. During the audit tour and staff interviews, when asked, staff reported that detainee victims are always separated from their alleged abuser. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

§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) During the pre-onsite audit, the PAQ indicated that staff, contractors, and volunteers, and immigration detention facility detainees, shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The PAQ indicated that ICE employs multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. During the onsite audit, the Warden stated that retaliation monitoring would include disciplinary reports, grievances, post reassignments, and negative performance reviews. He stated that the facility has an assigned retaliation monitor, who monitors housing changes, removal of alleged staff or detainee abusers from contact with victims for 30, 60, 90 days. Given the information provided, the auditor determined that the facility and agency meet the requirements of this standard.

(c) A review of the updated PAQ indicated that for at least 90 days following a report of sexual abuse, LPC and ICE monitor to see if there are facts that may suggest possible retaliation by detainees or staff. Both agency and facility act promptly to remedy any such retaliation. The PAQ indicated that monitoring includes any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. AFOD memorandum dated 9/29/21 stated that there has been no report of retaliation related to sexual abuse during this audit period. During the onsite audit, the auditor conducted onesexual abuse investigative file review on the incident that occurred within this audit period. Retaliation monitoring for the one detainee-on-detainee allegation was completed and confirmed. Given the above information, the auditor determined that the agency and facility meet the requirements of this standard.

§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) A review of the updated PAQ indicated that LPC places detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible, such as protective custody as it pertains to the requirements of §115.43. AFOD memorandum dated 10/11/21 stated that there were no instances of segregated housing being used to protect a detainee of sexual abuse during this audit period. During the onsite facility tour, the auditor observed and reviewed the logbook and confirmed that there were no detainees housed in protective custody or restrictive housing during this audit period as it pertains to sexual abuse. The Warden stated during his interview that the detainee victim would be separated from the alleged abuser and that he may ask the agency to transfer the detainee victim if protective custody is needed. The Warden reported that he tries not to place detainees in segregation or restrictive housing. Given the information provided, the auditor determined that that facility meets the requirements of this standard.

(b)(c) The PAQ indicated that LPC ensures detainee victims are not held in any type of administrative segregation for longer than five days except in highly unusual circumstances or at the request of the detainee. The PAQ indicated during the pre-onsite review, that LPC ensures detainee victims who are in protective custody after having been subjected to sexual abuse are properly reassessed before they are returned to general population. The reassessment takes into consideration any increased vulnerability of the detainees as a result of the sexual abuse. The auditor reviewed and confirmed that the reassessment takes such elements into consideration. During the onsite audit, the auditor conducted one sexual abuse investigative file review and found no indication of the detainee victim having been held in administrative segregation. Given the information provided, the auditor has determined that the facility meets the requirements of this standard.

(d) The PAQ indicated that LPC notifies the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours. During the audit tour, the Quality Assurance Manager and the PSA Compliance Manager stated that there were no detainees held in segregated or restrictive housing as a result of sexual abuse victimization during this audit period. During the onsite audit interview with the Warden, the auditor was informed that the facility notifies ICE when a detainee victim has been in protective custody for 72 hours. The auditor observed that there were no detainees housed in segregated or restrictive housing at the time of the audit. Given the above information, the auditor determined that the facility meets the requirements of this standard.

§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)(b) A review of the PAQ indicated that LPC has responsibility for investigating allegations of sexual abuse; all investigations into alleged sexual abuse are prompt, thorough, objective, and conducted by specially trained, qualified investigators. The facility also reported that upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation is conducted. The PAQ indicated that upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility reviews any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations are conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The auditor conducted one investigative file review of a detainee-on-detainee sexual abuse allegation occurring within this audit period. This administrative investigation case was closed and found to be unsubstantiated. Given the information provided, the auditor has determined that the facility meets the requirements of this standard.

(c) A review of the PAQ indicated that LPC has developed written procedures for administrative investigations, including provisions requiring: (1) preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, (2) interviewing alleged victims, suspected perpetrators, and witnesses, (3) reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator, (4) assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph, (5) an effort to determine whether actions or failures to act at the facility contributed to the abuse, (6) documentation of each investigation by written report, which includes a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings, (7) retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years, and (8) the coordination and sequencing of the two types of investigations, in accordance with paragraph (b) of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation. The auditor confirmed this through review of the facility's policy update and approval document which was signed by both the facility and the agency officials. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

(e)(f) The PAQ indicated that LPC "ensures the departure of the alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation." When outside agencies investigate sexual abuse, the PAQ indicated that LPC cooperates with outside investigators and attempts to remain informed about the progress of the investigation. The auditor interviewed the PSA Compliance Manager, while onsite, who stated that if the alleged abuser or victim leaves the facility during an investigation, the other detainee involved who is still in the facility will be informed and that the investigation will continue. The auditor reviewed one administrative investigative detainee-on-detainee case occurring during this audit period which did not require outside agency investigation. The auditor interviewed an assigned facility investigator who indicated a positive relationship with several key staff at the LPD and that LPC would receive continuous updates with the progress of the investigation.

§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:

A review of the updated PAQ indicated that when an administrative investigation is undertaken, the agency imposes no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. During the onsite audit, interviewed the facility investigator and conducted one file review of a detainee-on-detainee sexual abuse allegation in which the auditor found that the facility imposed no standard higher than a preponderance of evidence. The auditor reviewed the specialized investigative curriculum in which the facility investigators received training on imposing no standard higher than a preponderance of evidence to determine a substantiation. Given the above information, the auditor has determined that the facility meets the requirements of this standard.

§115.73 - Reporting to detainees.

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

Notes:

The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated, "Following an investigation into a detainee's allegation of sexual abuse, the detainee shall be notified as to the result of the investigation and any responsive action taken." The policy further requires, "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 facility Investigator confirmed detainees are informed of investigation outcomes regardless of the entity that completes the investigation. During the one administrative investigation case file review, the auditor reviewed a status notification provided by LPC informing the detainee that her case was closed with an unsubstantiated finding. During the onsite audit interview with the Warden, he stated that detainees are often gone by the time an investigation is completed. Given the above information provided, the auditor determined that the facility meets the requirements of this 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) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* stated, "Staff are subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies." The PAQ also indicated, "The facility provided policies and procedures regarding disciplinary or adverse actions for staff to the agency for review and approval. Removal from their position and from the Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined

under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." AFOD memorandum dated 10/11/21 stated that there were no termination, resignation, or other staff sanctions imposed for violating agency or facility policies during this audit period. There were no staff-on-detainee sexual abuse allegations for the auditor to review during the audit period. Also, the auditor conducted an interview with the Warden and was informed 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. He also reported that the facility has not been able to take disciplinary measures given that staff resigned prior to them ever receiving the sexual abuse report and the other sexual abuse report involving a staff perpetrator is under division review. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

(c)(d) The PAQ indicated that LPC reports all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies unless the activity was clearly not criminal. Also, the PAQ indicated that LPC makes 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. During the onsite interview with the Warden, the auditor was advised that the facility has not been able to go as far as removing staff from their duties as a result of such violation. There were two sexual abuse allegations reported during this audit period and the auditor conducted a file review on both to find that prior to receiving the report, the alleged staff perpetrator had already resigned. In addition, the other case is pending division review. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

§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) An interview with the PSA Compliance Manager indicated that it ensures that any contractor or volunteer who has engaged in sexual abuse is prohibited from contact with detainees. LPC also makes reasonable efforts to report substantiated allegations of sexual abuse by a contractor or volunteer to any relevant licensing body to the extent known. Also, the facility reported that such incidents are reported to law enforcement agencies, unless the activity was clearly not criminal. The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that contractors and volunteers suspected of perpetrating sexual abuse are removed from all duties requiring detainee contact pending the outcome of an investigation. The facility reported that there were no incidents of sexual abuse reported against a contractor or volunteer during this audit period. AFOD memorandum dated 10/11/21 stated that there were no contractor or volunteer terminations, resignations, or other sanctions imposed during this audit period. The auditor confirmed through the investigative file reviews that there were no incidents of sexual abuse involving contractors or volunteers. The Warden stated that the facility's policy addresses sexual abuse allegations involving contractors or volunteers and that reasonable efforts to report to a relevant licensing body and/or removal of all duties would be imposed as a result of a substantiated finding of sexual abuse. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

(c) LPC and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that the facility takes appropriate remedial measures and considers whether to prohibit further contact with detainees by contractors or volunteers who have engaged in sexual abuse but have violated other provisions within these standards. The facility reported that there were no incidents of sexual abuse reported against a contractor or volunteer during this audit period. AFOD memorandum dated 10/11/21 stated that there were no contractor or volunteer terminations, resignations, or other sanctions imposed during this audit period. The auditor confirmed through the investigative file reviews that there were no incidents of sexual abuse involving contractors or volunteers. Also, the Warden reported that there were no such incidents involving contractors or volunteers during this audit. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

§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 *15-100 Resident Rules and Discipline* indicated that LPC "subjects a detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse. Any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future." LPC and Policy 15-100 indicated that LPC has a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure. Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that detainees are subject to disciplinary sanctions in accordance with this standard. AFOD memorandum dated 10/11/21 stated that there were no disciplinary sanctions imposed upon a detainee for engaging in sexual abuse during this audit period. The auditor conducted one investigative file review of a detainee-on-detainee sexual abuse allegation occurring within this audit period and confirmed no disciplinary sanctions were applied. The Warden stated, during the onsite interview, that they would likely ask ICE to transfer a detainee, or the detainee could be disciplined by loss of privileges after receiving a disciplinary infraction for engaging in such activity. The Warden also reported that there are progressive levels of the facility's disciplinary system. He reported that the Disciplinary Team consists of captains and the assistant shift supervisor. The Warden also stated that disciplinary measures include restriction of commissary and recreation, but that he does not like to use restrictive housing for disciplinary measures. Given the above information, the auditor determined that the facility meets the requirements of this standard.

(d)(e)(f) The PAQ indicated that the disciplinary process considers whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. LPC does not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. The PAQ indicated that 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. Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that if a detainee has a mental illness but is competent, the disciplinary process will consider whether the detainee's mental illness contributed to his/her behavior when determining what type of sanction should be imposed. It also states that a detainee may be disciplined for sexual misconduct with an employee only upon finding that the employee did not consent to such activity. There were no reports of a detainee with mental disabilities or mental illness being involved in a sexual abuse allegation or sexual misconduct allegation during this audit period. When asked for a listing of all detainees with mental and physical disabilities on day one of the onsite audit, the auditor was informed that there were none. This information was further confirmed by medical staff. The auditor conducted three sexual abuse and one sexual misconduct file reviews while onsite and the files did not indicate that the detainee victims or complainants had a mental disability or illness. The auditor conducted a total of 15 detainee interviews. None of the 15 reported having a mental disability or mental illness. The auditor did not observe such disabilities during the interviews. Given the above information, the auditor determined that the facility meets the requirements of this 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) The facility reported through the PAQ that if the assessment pursuant to §115.41 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 working days from the date of assessment. Also, when a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral. AFOD memorandum dated 10/11/21 indicated that there were no instances of a medical follow up for a detainee who previously experienced sexual victimization or perpetrated sexual abuse during this audit period. During the onsite audit, the auditor conducted two interviews of detainees who reported a sexual abuse history, but this was not during the initial risk assessment pursuant to 115.41. During the onsite audit tour, the Quality Assurance Manager stated that detainees who report sexual abuse history are seen by medical and mental health immediately. Given the information provided, the auditor determined that the facility meets the requirements of this 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) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated, "Detainee victims of sexual abuse 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. Emergency medical treatment services provided to the victim are without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." AFOD memorandum dated 10/11/21 stated that there were no instances of emergency medical or mental health services that were provided to a detainee victim during this audit period. During the onsite audit tour, the auditor was informed by medical staff that medical treatment stemming from a sexual abuse incident would be provided at no cost to the detainee. They also reported that the facility has an MOU with Doctors Hospital Center to provide such services at no cost to the detainee. The auditor reviewed the MOU and confirmed these services are provided, and at no cost to the detainee. The auditor conducted an onsite tour of the facility and was informed by medical staff that if there were an allegation of sexual abuse, they would send the detainee to the hospital to have a sexual assault examination conducted. During the onsite audit, the auditor reviewed one detainee-on-detainee sexual abuse allegation and found the allegation did not include physical contact and the facility determined access to emergency medical service was not required. They reported that the facility has an MOU with Doctors Hospital Center. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

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

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

Notes:

(a)(b)(c)(d) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that the facility offers 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 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. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated are 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. The auditor conducted an onsite tour of the facility and was informed by medical staff that if there were an allegation of sexual abuse, the facility would send the detainee to the hospital to have a sexual assault forensic examination conducted, if appropriate. They reported that the facility has an MOU with Doctors Hospital Center. The auditor was also informed that medical treatment, to include prophylaxis, would be provided to detainees at no cost and that the detainees would receive such services at no cost. The auditor confirmed that the MOU with Doctors Hospital Center indicated the standard required services. In addition, the auditor was informed that upon return to the facility, the detainee would be seen by medical and mental health staff. The auditor attempted to contact a SANE at Doctors Hospital Center while onsite and left a message. However, the auditor did not receive a returned call. During interview, each of the two detainees reported that after reporting such victimization, they were seen by medical and/or provided a mental health evaluation. One detainee reported that she

was seen by medical and mental health about a week after reporting. One detainee expressed her interests in receiving ongoing mental health and emotional support services. Therefore, the auditor made the referral and was advised that the detainee was scheduled for a follow up within two days. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

(e)(f)(g) The PAQ and Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated, "Detainee victims of sexual abuse while detained are offered tests for sexually transmitted infections as medically appropriate. Treatment services are 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. LPC attempts 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." AFOD memorandum dated 10/11/21 indicated that there hasn't been a need to conduct a mental health evaluation of detainee-on-detainee abuser within 60 days of learning of such abuse history. The auditor conducted an onsite tour of the facility and was informed by medical staff that if there were an allegation of sexual abuse, they would send the detainee to the hospital to have a sexual assault examination conducted. They reported that the facility has an MOU with Doctors Hospital Center. The auditor was also informed that medical treatment, to include prophylaxis, would be provided to detainees at no cost. In addition, the auditor was informed that upon return to the facility, the detainee would be seen by medical and mental health staff. The auditor reviewed the current MOU between LPC and Doctors Hospital Center and confirmed that the hospital would provide such services to detainee victims of sexual abuse. Given the information provided, the auditor determined that the facility meets the requirements of this 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) A review of the updated PAQ indicated that LPC conducts a sexual abuse incident review at the conclusion of every investigation of sexual abuse. LPC also reported through the PAQ that when an allegation was not determined to be unfounded, the facility prepares a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The facility reported that the written report is provided within 30 days of the conclusion of the investigation. The PAQ indicated that LPC implements the recommendations for improvement or documents its reasons for not doing so in a written response. Both the report and response are forwarded to the agency PSA Coordinator. During the onsite audit interview with the PSA Compliance Manager, the auditor was informed that incident reviews are conducted seven days after the closure of a sexual abuse case. He reported that the review team includes medical, shift captains, the Warden, and himself. Also, the Warden reports to the agency's PSA Coordinator. The auditor conducted one investigative file review of a detainee-on-detainee sexual abuse allegation occurring within this audit period. According to the investigative file review, a sexual abuse incident review was completed within 30 days of the detainee-on-detainee investigation completion.

(b) The PAQ indicated that the review team considers whether the incident or allegation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status, gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility. The PSA Compliance Manager reported that the review team includes medical, shift captains, the Warden, and himself. He stated that the review team takes the above elements into consideration, and the Warden reports to the ICE PSA Coordinator. A review of the one closed case incident review occurring during this review period, confirmed the incident review team considered all the necessary criteria of this component. Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated that "such reviews are conducted on all sexual abuse incidents after the investigation is completed and where the allegation was not determined to be unfounded." Given the information provided, the auditor determined that the facility meets the requirements of this standard.

(c) Prior to the onsite audit, the PAQ indicated that LPC conducts an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, LPC prepares a negative report. The results and findings of the annual review are provided to the facility administrator, Field Office Director or his or her designee, and the agency PSA Coordinator. The LPC 2020 PREA Annual Report indicated that there were no substantiated, unsubstantiated, unfounded, or pending employee-on-detainee or detainee-on-detainee sexual abuse incidents. The PSA Compliance Manager stated during the onsite audit interview that the facility conducts an annual review of its sexual abuse investigations and incident reviews. He reported that as a result of the annual review (2020), there were no improvements needed. In addition, the PSA Compliance Manager stated that the facility used to have a bad camera system, but the updated system is really effective. Also, during the onsite audit, the Warden stated that they review annual sexual abuse incidents and findings, which are reported to the "AFOD and SDDO." Given the information provided, the auditor determined that the facility meets the requirements of this standard.

§115.87 - Data collection.

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

Notes:

(a) The PAQ indicated that LPC maintains in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary, and/or counseling in accordance with these standards and applicable agency policies, and in accordance with established schedules. The DHS Office of Inspector General maintains the official investigative file related to claims of sexual abuse investigated by the DHS Office of Inspector General. Policy *14-2 DHS Sexual Abuse Prevention and Response* indicated

that all case records of sexual abuse, to include the above requirements, are retained in accordance with the facility's Policy *1-5 Retention of Records*. The auditor reviewed and confirmed this policy. During the onsite interview, the PSA Coordinator stated that PREA records are kept in a file cabinet under lock and key. He stated that the Warden, the ADO, and himself have access to the cabinet. The auditor observed the file cabinet in the hallway in the administrative office area of the facility. The auditor advised that the file cabinet should be in a more private and secure location to reduce human error and breach of confidentiality. On the following day, the auditor noticed that the cabinet had been removed to the recommended location to ensure safety and security of sensitive files. Given the information provided, the auditor determined that the facility meets the requirements of this standard.

§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 were allowed access to the entire facility and able to interview staff and detainees about sexual safety during the on-site visit.
(e) The Auditor were able to revisit areas of the facility and to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j) Audit notices were posted and observed throughout the facility in English and Spanish. The Auditors 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:	2
Number of standards met:	38
Number of standards not met:	0
Number of standards N/A:	1
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 2/7/2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) 2/8/2022
PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C)
PREA Program Manager's Signature & Date 2/9/2022

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