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

Homeland Security

| AUDIT DATES | | | |
|---|---|---|---|
| **From:** | 5/25/2021 | **To:** | 5/27/2021 |
| **AUDITOR INFORMATION** | | | |
| **Name of auditor:** | Valerie Wolfe Mahfood | **Organization:** | Creative Corrections |
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| **AGENCY INFORMATION** | | | |
| **Name of agency:** | U.S. Immigration and Customs Enforcement (ICE) | | |

| FIELD OFFICE INFORMATION | |
|---|---|
| **Name of Field Office:** | San Antonio |
| **Field Office Director:** | Jose Correa |
| **ERO PREA Field Coordinator:** | (b) (6), (b) (7)(C) |
| **Field Office HQ physical address:** | 1777 Northeast Interstate 410 Loop 100, San Antonio, Texas, 78217 |
| **Mailing address:** (if different from above) | |

| INFORMATION ABOUT THE FACILITY BEING AUDITED | | | |
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| **Basic Information About the Facility** | | | |
| **Name of facility:** | South Texas Family Residential Center | | |
| **Physical address:** | 300 El Rancho Way, Dilley, Texas, 78017 | | |
| **Mailing address:** (if different from above) | | | |
| **Telephone number:** | (830) 378-6500 | | |
| **Facility type:** | FAMILY | | |
| **PREA Incorporation Date:** | 9/18/2015 | | |
| **Facility Leadership** | | | |
| **Name of Officer in Charge:** | (b) (6), (b) (7)(C) | **Title:** | Facility Administrator |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | (830) 965- |
| **Name of PSA Compliance Manager:** | (b) (6), (b) (7)(C) | **Title:** | Assistant Facility Administrator |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | (512) 709- |

| ICE HQ USE ONLY | |
|---|---|
| **Form Key:** | 29 |
| **Revision Date:** | 02/24/2020 |
| **Notes:** | |

## 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 Prison Rape Elimination Act (PREA) audit of the South Texas Family Residential Center (STFRC), located in Dilley, Texas, was conducted May 25-27, 2021. The purpose of this audit was to determine compliance with the U.S. Department of Homeland Security (DHS) PREA standards. The audit was conducted by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Dr. Valerie Wolfe Mahfood and accompanying the Auditor was (b) (6), (b) (7)(C) Immigration and Customs Enforcement (ICE) PREA Program Manager, both contractors employed with Creative Corrections, LLC. Guidance and review of the report writing process was provided by the ICE PREA Program Manager, (b) (6), (b) (7)(C) and Assistant ICE PREA Program Manager, (b) (6), (b) (7)(C) who are both DOJ and DHS certified PREA Auditors. The role of the Program Manager is to provide oversight to the ICE PREA audit process and liaison with the ICE External Reviews and Analysis Unit (ERAU) during the audit report review process.

The STFRC is privately operated by CoreCivic and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility houses resident families with juvenile children pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the most populated nationalities assigned to the STFRC are from El Salvador, Guatemala, and Honduras. This is the second PREA audit for STFRC.

The point of contact for the audit was (b) (6), (b) (7)(C) Team Lead, Inspection and Compliance Specialist (ICS), ICE, Office of Professional Responsibility (OPR), ERAU. About one month prior to the audit, the Team Lead provided the Auditor with the facility's PAQ, facility and agency policies, exhibits, and other pertinent documents. The documentation was provided through the ICE ERAU SharePoint. This documentation was reviewed by the Auditor prior to the on-site visit.

On May 25, 2021, at 08:15 A.M., the Team Lead began the entry briefing. In attendance were:

(b) (6), (b) (7)(C) – ICS, ICE, OPR, ERAU
(b) (6), (b) (7)(C) – Creative Corrections ICE PREA Program Manager
(b) (6), (b) (7)(C) –Management Program Analyst (MPA), ICE, ERO
Valerie Wolfe Mahfood – DHS/DOJ Certified Auditor, Creative Corrections
(b) (6), (b) (7)(C) –Supervisory Detention and Deportation Officer (SDDO), ICE, ERO
(b) (6), (b) (7)(C) – PREA Coordinator, CoreCivic
(b) (6), (b) (7)(C) – Prevention of Sexual Assault (PSA) Compliance Manager/Assistant Facility Administrator, CoreCivic

The Auditor and the ICE PREA Program Manager introduced themselves and provided a brief overview of the audit process, to include the methodology necessary to demonstrate PREA compliance. The Auditor explained that the auditing process uses a triangulation method of written documentation, Auditor observations, and staff and resident interviews to assess the institutionalization of PREA standards. At that time, the Auditor was informed that the STFRC presently held 389 residents.

At 08:30 A.M., the on-site review began in the ICE Administration Building, which is located outside of the facility. Entering STFRC through the facility entrance, the Auditor first inspected the intake area. At that time, the STFRC was receiving residents via bus transport. The Auditor was able to observe the initial intake process, however, due to time constraints, it would be necessary to return to the intake process at a later time in order to observe screening interviews. In observing the intake area, it was noted that there was one large holding room with two restrooms, separated by gender, for use by residents. There were seven shower stalls for residents to utilize once received into the facility. These showers were monitored by the same gender staff as the residents utilizing them. (b) (7)(E) The intake process occurring in the intake area upon arrival includes the review of initial intake paperwork, detainee showering, medical assessment, clothing issue, and ICE orientation provided by ICE staff. Once those activities are completed, intake staff continue the intake processing with the completion of intake paperwork, to include a PREA risk assessment.

The Auditor visited all areas of the facility where residents are provided access. This included housing areas, medical services, recreation, food service, the visitation area, as well as the facility support services such as education, laundry, and monitored childcare; and resident services such as the commissary, barber shop, and library. (b) (7)(E)

As a family residential center, the facility houses adult males, adult females, and juveniles of both sexes. There are five housing neighborhoods: Green Turtle, Red Parrot, Yellow Frog, Blue Butterfly, and Brown Bear, each consisting of four complexes, with ten suites in each complex. Suites consist of either 6 or 3 double-bunked beds allowing 12 or 6 persons in each suite. In the Brown Bear neighborhood, the suites there are only three double-bunked beds providing housing for six persons. In housing suites with six bunks, a separation wall places three bunks on one side of the room and three bunks on the other side of the room. Either section of the room has a privacy curtain to allow residents a small space to draw the curtain and change clothes without being seen by other persons and staff of the opposite gender. Generally speaking, families are housed in accordance with their gender and age. All juvenile males ages 14 and older are housed in the Brown Bear neighborhood, in the same suite as their fathers. The remaining neighborhoods are reserved for mothers and their children. All juveniles 13 years of age or younger, regardless of gender, are housed with their mothers. Mothers with children six years of age or younger may be housed in the same suite with other families. Mothers with children seven years or older are placed in suites without other families.

When entering into any suite within these neighborhoods, there is initially an open living room space consisting of sitting areas, tables, televisions (where the PREA informational video, with sound, is available), and a phone available to make calls. Behind the living room area are the housing bunks.

All neighborhood toilets, showers, and sinks are in a communal bathroom for each complex. Bathroom facilities are separated by gender. Juveniles eight years of age and younger must be escorted in the bathroom by their mother. Juveniles nine years of age and older may utilize the facilities without an escort. In neighborhood bathrooms, there are five sinks, seven toilet stalls, and eight showers, with one of those showers being Americans with Disabilities Act (ADA) complaint. Each toilet, as well as each shower, is contained within individualized stalls so as to provide maximum privacy to individual users.

There are two other large communal bathrooms within the facility. The communal bathrooms located outside of the dining facilities are slightly different dependent on gender. For females, there seven toilet stalls and five sinks. For males, there are seven toilet stalls, three urinals, and four sinks. The last set of communal bathrooms is in the education area. There are two sets of bathrooms here, one on each side of the education area. These bathrooms are gender specific. Their use is also governed by age, with juveniles seven years and younger being required to use one set of bathrooms and juveniles eight years and older being required to use the other set of bathrooms.

Inside each neighborhood complex, there is an activity room and phone room. The activity room contains a television, where the PREA informational video, with sound, is available. The phone room contains five phones with open seating and three phones located inside of privacy booths. There is also one phone located in each housing suite. Also, inside the neighborhoods, and throughout the facility, there is a proliferation of zero-tolerance posters in both English and Spanish. During the on-site review, it was noted that the contact information on these posters was incorrect. The name of the PSA Compliance Manager and the name of local organizations that can assist residents who have been victims of sexual abuse and assault were missing from the poster. This was brought to the attention of facility staff at the beginning of the on-site review. This information was subsequently updated on all advisement notices (approximately 300 throughout the facility) prior to end of the on-site review. Accordingly, no further action is needed.

Resident Supervisors, as well as supervisory staff, record their routine security checks, as well as other pertinent information, in the Security Round Book located in the activity rooms of each neighborhood complex. Also, Security Round Books are located at other Resident Supervisor stations throughout the facility, such as medical housing units and resident's activity areas. During the on-site review, six of these books were randomly checked for the presence of unannounced supervisory rounds. These inspections verified that supervisory staff of all levels were routinely conducting unannounced rounds throughout the facility.

Inside the medical department, there is temporary housing for those with medical needs. The hospital rooms are designed as either single rooms with their own bathroom or as two adjoining rooms with a communal bathroom shared between those rooms. For the adjoining rooms, the bathroom doors lock from the inside to allow for privacy. When medical staff were asked how potential cross-gender viewing during the use of communal bathrooms was prevented, the Auditor was advised that while facility protocol does not require such, it is standard operating procedure that only females and children are housed in the hospital infirmary. Whereas males are housed in the hospital isolation area. It was recommended that protocol be updated to reflect standard operating procedure.

The medical department isolation area consists of six rooms with single beds. Looking from the hallway into the rooms, there was a clear view of the bed, a shower with a privacy curtain, and a toilet. During the on-site review, it was brought to the attention of facility staff that residents should be able to utilize the toilet without being viewed by members of the opposite gender who may be walking through the halls. The facility took immediate action to address this concern by installing a privacy curtain that can be pulled shut when the toilet is in use. Accordingly, no further action is required. STFRC has two medical triage areas outside of the unit infirmary. Blue Triage can be used by men, women, and their children. Red Triage only serves women and their children.

PREA notices and zero-tolerance posters are displayed within the library. The PREA informational video is continuously shown on library television sets. Generally, the volume is lowered on this video. However, residents are allowed to increase the volume to listen to the video or they can read the captioned information at the bottom of the screen. A summary pamphlet of the ICE PREA standards, as well as the facility policy, are available in both English and Spanish. The STFRC handbook, in both English and Spanish, is also available.

The Auditor formally interviewed 30 staff members, including 9 Resident Supervisors, 5 contractors, 3 line-class supervisors, 2 medical staff, a mental health staff, the PSA Compliance Manager, an Intake Resident Supervisor, a Resident Counselor, a Case Manager (Retaliation Monitor), the Facility Administrator, the Facility Investigator, a SDDO, the Training Supervisor, the Human Resources Manager, and the Grievance Coordinator.

A total of 20 residents were formally interviewed. All 20 detainees were limited English proficient and required the use of a language line, which was facilitated via Language Services Associates (LSA) as provided through contract with Creative Corrections, LLC. The residents were from Honduras (10), Haiti (3), Guatemala (4), Venezuela (2), and Romania (1). Seventeen of the detainees were female and 3 were male. Other than all of residents being LEP, none of them self-identified in any other targeted category.

There were four allegations of sexual abuse reported during the audit time period of May 2020 through May 24, 2021. One allegation of resident-on-resident sexual abuse was unsubstantiated. Three allegations were staff-on-resident, with investigative outcomes of one unfounded, one unsubstantiated, and one substantiated.

On May 27, 2021, at 4:30 P.M., the Team Lead began the exit briefing. In attendance were:

(b) (6), (b) (7)(C) – CoreCivic Assistant Facility Administrator (via phone)
(b) (6), (b) (7)(C) – ICS, OPR, ICE, ERAU
(b) (6), (b) (7)(C) – Creative Corrections ICE PREA Program Manager

Valerie Wolfe Mahfood – DHS/DOJ Certified Auditor, Creative Corrections

(b) (6), (b) (7)(C) – SDDO, ICE, ERO

(b) (6), (b) (7)(C) – Facility Administrator, CoreCivic (via phone)

(b) (6), (b) (7)(C) – ICE Compliance, ICE, ERO

(b) (6), (b) (7)(C) – PSA Compliance Manager/Assistant Facility Administrator, CoreCivic (via phone)

The Auditor, as well as the ICE PREA Program Manager, spoke briefly about their observations. Specific areas of concern where corrective action had already occurred were discussed. Specific areas of concern where recommendations were thought necessary were also discussed. Otherwise, it was noted that staff assigned to the STFRC did take allegations of sexual abuse seriously. As well, it was noted that staff firmly believed in the facility's culture of preventing, detecting, and responding to sexual misconduct.

## 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 Exceeds: 2**

115.31 Staff training
115.32 Other training

**Number of Standards Met: 32**

115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
115.13 Detainee supervision and monitoring
115.14 Juvenile and family detainees
115.15 Limits to cross-gender viewing and searches
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
115.34 Specialized training: Investigations
115.35 Specialized training: Medical and mental health care
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
115.73 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 care for sexual abuse victims and abusers
115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
115.86 Sexual abuse incident reviews
115.87 Data collection
115.201 Scope of audits

**Number of Standards Not Meet: 6**

115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
115.33 Detainee education
115.41 Assessment for risk of victimization and abusiveness
115.42 Use of assessment information
115.71 Criminal and administrative investigations
115.82 Access to emergency medical and mental health services

**Number of Standards Not Applicable: 1**

115.18 Upgrades to facilities and technologies

## 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): ICE Policy #11062.2, Sexual Abuse and Assault Prevention and Intervention, provides an agency-wide response to sexual abuse in a confinement setting. More specifically, the STFRC Policy #14-2-FRS, Sexual Abuse Prevention and Response, provides a facility specific approach to preventing, detecting, and responding to such conduct. The facility has provided the facility policy to the agency for review and approval.

(d): The STFRC does employ a PSA Compliance Manager. This position is included within the upper hierarchy of the facility's organizational chart. Interviewing the PSA Compliance Manager verified that she is both the point of contact for the agency's PSA Coordinator and has sufficient time and authority to oversee the facility's efforts to comply with its zero-tolerance policy.

### §115.13 - Detainee supervision and monitoring.

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

**Notes:**

(a)(b)(c): Policy #14-2-FRS requires an annual review of the facility's staffing plan. The STFRC's last Annual PREA Staffing Plan Assessment was completed at the facility level on April 8, 2021. The facility does use a staff-to-resident ratio, as well as video monitoring, to determine appropriate staffing levels. During the on-site review, ample video monitoring devices were noted throughout the facility. (b) (7)(E) [redacted] Policy #14-2-FRS requires the annual review of the facility's staffing plan to include the need for video monitoring; generally accepted detention/correctional practices; any judicial findings of inadequacy; the physical plant; detainee population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; any findings and recommendations of incidents of sexual abuse; the length of time residents spend in agency custody; and any other relevant factors. In the facility completing its last staffing review, the PSA Compliance Manager and Facility Administrator both confirmed the aforementioned factors were given significant consideration. The documentation review of the staffing plan, as well as staff interviews, confirms that the facility has developed a series of comprehensive resident supervision guidelines.

(d): Policy #COR-PO-01-FRS, Shift Supervisor Post Orders, requires supervisory staff to conduct unannounced security inspections of areas occupied by residents on a daily basis and all unoccupied areas on a weekly basis, for all three shifts, in order to identify and deter sexual abuse. Supervisors are required to document these rounds in the appropriate log, such as the Security Rounds Book. During the on-site review, six random logs throughout the facility neighborhoods and resident's activity areas were inspected. It was noted that supervisory staff were conducting and properly documenting unannounced security inspections in each occupied area at least once per shift. Staff are prohibited from alerting other employees that these supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the facility. Interviews with both resident supervisors and shift supervisors confirmed staffs' awareness to this policy, via their annual and refresher PREA trainings, as well as their adherence to this policy as evidenced via unannounced rounds being conducted as an institutionalized practice.

### §115.14 - Juvenile and family detainees.

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

**Notes:**

(a)(b): According to intake staff, to ensure the least restrictive setting appropriate to the juvenile's age and special needs, each juvenile is placed with a responsible parent in accordance with the housing assignment family matrix schedule. As a family residential center, the facility houses adult males, adult females, and juveniles of both sexes. There are five housing neighborhoods: Green Turtle, Red Parrot, Yellow Frog, Blue Butterfly, and Brown Bear, each consisting of four complexes, with ten suites in each complex. Suites consist of either six or three double-bunked beds. Thus allowing 12 or 6 persons to be housed in each suite. Generally speaking, families are housed in accordance with the gender of the resident and age of the child(ren). All adult male residents are housed in the Brown Bear neighborhood, with juvenile males age fourteen and older being housed in the same suite as their fathers. The remaining neighborhoods are reserved for mothers and their children. All juveniles thirteen years of age or younger, regardless of gender, are housed with their mothers. Mothers with children six years of age or younger may be housed in the same suite with other families. Mothers with children seven years or older are placed in suites without other families. A mother with a juvenile male child fourteen years of age or older without a father, the mother and children will be housed in a suite of their own, without another family. The Intake Supervisor stated, for example, a 4-year-old girl will not be housed with a 12-year-old boy unless they are the same family group. At which point in time, they would have to be housed in the appropriate neighborhood in an individualized suite to accommodate that specific age range need.

Juveniles are required to remain in the presence of an adult family member at all times with the exception only of utilizing bathroom facilities to prevent cross-gender viewing given the age of the juvenile (seven years or older) and the gender of the accompanying parent. If the same gender parent is not present to escort the juvenile into the restroom, interviews with resident supervisors confirm standard operating procedure is for resident supervisors to ensure there are no adults present in the restroom area before allowing the juvenile to enter the restroom. Resident supervisors will then wait outside of the restroom prohibiting incoming adult traffic until the juvenile exits the restroom facilities and is reunited with the responsible parent.

(c): As observed during the on-site review, evidence of a familial relationship is established during the intake process. Namely, the Resident Supervisors first review the family resident files documenting each individual received into STFRC. In speaking with each resident family member, the information contained within each file is confirmed, as well as supplemented with additional information as provided by the resident.

(d): At the time of the on-site review, per the facility administrator, there weren't any unaccompanied children housed at the STFRC.

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

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

**Notes:**

(b)(c)(d)(e)(f): Policy #9-104.1, Searches of Residents, and Policy #14-2-FRS do not allow for cross-gender searches, regardless of search type, under any circumstances. All searches are documented in both the logs used to record searches and within the resident's residential file. CoreCivic staff are prohibited from engaging in strip searches and body cavity searches. Strip searches can only be performed by two ICE staff members of the same gender as the resident. Policy requires all body cavity searches to be conducted by qualified medical practitioners. Pat searches of juvenile, age 14 or younger, requires express authorization from the facility administrator or the assistant facility administrator. A parent must also be present during any search of a child. Strip searches and body cavity searches of juveniles under the age of 14 requires authorization of the ICE Field Office Director (FOD) and the Chief of Juvenile and Family Residential Management Unit. When interviewing the ICE PREA SDDO, adherence to said policy requirements were confirmed. During the audit time-frame, there have been no instances of staff conducting any searches on residents, to include pat-searches, strip-searches, and body-cavity searches. Nonetheless, interviews with residential supervisors confirmed staffs' awareness of policy, as well as staffs' adherence to said policy.

(g)(h): Policy #CO-PO-00-FRS requires residential supervisors to knock and announce prior to entering any area where a resident may be in a state of undress. Short of exigent circumstances, opposite gender staff are not permitted to enter opposite gender restroom facilities without first knocking and announcing and then waiting for residents to become clothed and exit the facilities. In speaking with Resident Supervisors, it was noted that agency staff do strictly adhere to this policy. Staff adherence to the knock and announce policy was further confirmed via resident interviews. During the on-site review, staff were observed engaging the knock and announce process prior to entering any housing area. Before entering restroom facilities, the same gender staff were observed engaging in the knock and announce process.

(i): Policy #9-104.1 strictly forbids searching a detainee solely for the purpose of determining that person's gender. If a resident's gender is unknown, it can be established by talking with the resident, reviewing medical records, or, if necessary, via the standard medical examination conducted by qualified medical practitioners that all residents must undergo during the intake process. Policy #14-2-FRS does not permit transgender and/or intersex residents to be assigned to the STFRC. If a transgender or intersex resident is transferred to the facility, that individual will remain in the intake area until transferred to another facility by ICE/ERO. Accordingly, there weren't any transgender or intersex residents at STFRC to be interviewed. However, all staff interviewed did understand the policy regarding proper search procedures and limits to searching.

(j): Training curriculum was reviewed to ensure staff are properly trained on how to conduct proper pat-searches on all detainees. Additionally, the Training Supervisor was interviewed to discuss the training curriculum, its frequency, and the number resident supervisor staff who have received said training. In this, it was noted that all CoreCivic staff and contractors have participated in mandatory ICE training intitled "Cross-Gender, Transgender, and Intersex Searches," which works to ensure residents are searched in the least intrusive manner possible consistent with maintaining staff safety.

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

**Outcome:** Does not Meet Standard (requires corrective action)

**Notes:**

(a)(b): In accordance to 14-2-FRS, appropriate steps are not being taken to ensure that residents with disabilities or those who are LEP 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. As was explained to the Auditor, residents who are deaf or hard of hearing are provided access to an American Sign Language interpreter via electronic tablet. That said, it's unlikely that an immigrant entering the country is going to already know how to communicate via American Sign Language. As such, it would be more appropriate for a sign interpreter of the resident's native language. The spoken language and the written language also carry the same concern. At intake, all residents received PREA orientation in Spanish. For the significant majority of Spanish speaking residents in intake, that was fine. But for the smaller percentage of residents who did not speak Spanish, or didn't speak it well, the language translation services were not always being used to translate PREA information to residents who are limited English/Spanish proficient. For residents who are blind or have limited reading skills, sexual abuse information can be provided in an audible format. However, it should be noted at intake, the PREA Orientation Video was being played with muted soun; and therefore, not providing the PREA information in a manner a blind or limited reading skill detainee can understand. Mental health counselors are available to assist those residents with intellectual disabilities. In interviewing residents, the majority of them spoke Spanish. With the exception of one such resident, all native Spanish speaking residents stated that they received the PREA information in a meaningful way. Two other language groups were interviewed, with the sole resident in one group (Romanian) stating that staff had used the language line to communicate with her. In the second group of residents, Spanish is a typical second language for many citizens of their county (Haiti). However, three residents interviewed from Haiti all expressed that they had limited Spanish proficiency. Thus, it was difficult for them to understand the PREA information in a meaningful way as it was provided in Spanish. In speaking with the PSA Compliance Manager, it was stressed that regardless of the resident's disability, to include limited English/Spanish proficiency, the facility would make every effort possible to educate those residents on the agency's zero-tolerance policy.

During the Intake process, access to the language line allows all residents to audibly receive PREA information, as well as to receive a PREA assessment, in their native language. While most persons assigned to the intake Department at STFRC speak both English and Spanish, there are still significant differences in Spanish dialects across Spanish speaking countries. As well, the PREA assessment contains formalized words which may not be commonly used in an individual staff member's personal vocabulary of language specific words. For example, in administrating the PREA assessment during the on-site review, a staff member who was not sufficiently fluent in Spanish was observed asking a second staff member how to translate specific English words into Spanish. This would suggest that the staff still may or may not have adequate knowledge of the Spanish language to fully interpret the resident's answers, especially considering regional dialects. Accordingly, if a staff member administering the PREA assessment in the Spanish language is not fully aware of how one should formally express specific words within the PREA screening instrument, it is recommended that said staff utilize the language line to engage the entire PREA screening instrument as written.

**Does Not Meet:** (a)(b) For residents who are blind or have limited reading skills, sexual abuse information was not provided in an audible format, and the language translation services were not always being used to translate PREA information to those residents who are limited English/Spanish proficient. To ensure that residents with visual disabilities, or those who simply cannot read, have equal access to the information contained within the PREA video, the facility staff must increase the volume of the televisions to levels that allow all persons the opportunity to hear the information being presented during the intake process. While residents at the STFRC can obtain copies of the PREA video in differing languages at the facility library, the intake department must maintain its own copies of the PREA video in differing languages so that all residents, regardless of their natural language, will

have equal opportunity to see and hear the information contained in the PREA video during the intake process. If the PREA video is not available in a language the resident understands, translation services must be provided via the language line or staff member. The facility must take appropriate steps to ensure residents with disabilities or those who are LEP 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. Additional documentation needed to confirm compliance will depend on the method(s) in which the facility employs to meet the standard requirements.

**Recommendation:** Given that Spanish is the assumed language of STFRC residents, it is recommended that the facility utilize a sign language resource for Spanish-speakers, such as an organization of trilingual (Spanish-English-ASL) interpreters, to provide effective translation services for residents who are deaf or hard of hearing.

(c): Policy #14-2-FRS requires that residents are provided with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation. The STFRC generally uses language line services to communicate with residents in languages other than Spanish and English. Policy #14-2-FRS further states that "when a resident expresses a preference for another resident to provide interpretation services, the agency will make a case by case determination if such interpretation would be appropriate and consistent with DHS policy." Lastly, Policy #14-2-FRS expressly notes that interpretative services for communication specific to sexual abuse cannot be provided by minors, the alleged abusers, detainees who witnessed the alleged abuse, or by detainees who have a significant relationship with the alleged abuser. In speaking with intake and security staff, including line staff and first-line supervisors, it was noted that the use of the language line services for residents who cannot communicate in Spanish or English is common practice. In review of the investigative files, there was no documentation provided that indicated whether effective, accurate, and impartial interpretation was utilized.

### §115.17 - Hiring and promotion decisions.

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

**Notes:**

(a)(b)(e)(f): Executive Order 10450, Security Requirements for Government Employment, Office of Personal Management, Section Part 731, and ICE Directives 6-7.0 and 6-8.0, require that "the facility and agency, to the extent permitted by law, to refuse to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor or volunteer who may have contact with detainees, 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." As such, CoreCivic procedure requires that all new hires, currently employed staff, recently promoted staff, contractors, and volunteers complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form on an annual basis. As a function of this form, the employee meets his/her continued affirmative duty to report any previous sexual misconduct as noted within this standard. During the interview process, new hires and employees seeking promotions are questioned directly regarding sexual misconduct. An affirmative response to these questions, as well as material omissions and making false statements regarding such, renders candidates unsuitable for employment with the agency. The STFRC Human Resources (HR) Manager confirmed adherence to said policies. As well, she confirmed the facility's willingness to, upon the request from an institutional employer for which the employee has sought new employment, provide information on substantiated allegations of sexual abuse involving former employees. Likewise, CoreCivic also requests relevant information from any institutional employer where an applicant listed having previously worked. These standards are also echoed in CoreCivic policy #14-2-FRS. The Auditor reviewed the Self-Declaration of Sexual Abuse/Sexual Harassment form on newly promoted staff to ensure said forms had been completed as required.

(c)(d): Federal Statute 731.105 and ICE Directives 6-7.0 and 6-8.0 require "the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees prior to being allowed entrance into the facility. It further requires a subsequent background check be conducted every five years on all employees and unescorted contractors." The STFRC Human Resources Manager noted that ICE completes all background checks for all staff and contractors prior to hiring. As well, ICE conducts subsequent checks every five years. The Auditor reviewed background checks completed on newly hired and current employees, including those of CoreCivic (7), ICE (2), ICE Health Services Corps (2), and contracted workers (3). Of the fourteen employee files reviewed, there were completed background checks dated prior to the actual start dates and Self-Declaration of Sexual Abuse/Sexual Harassment forms in all but one instance. Of the employee files reviewed, three people had been employed by the agency for greater than five years. All three files were reviewed for subsequent background checks, which were found to have been completed at the five-year increment.

Three volunteers were also selected for review. Volunteers are reviewed every 90 days. However, since COVID, volunteers have not been permitted into the facility. The last of all active volunteers expired approximately July 2020. As such, there are no active volunteers in the PSU database to verify appropriate background checks had been conducted.

### §115.18 - Upgrades to facilities and technologies.

**Outcome:** Not Applicable (provide explanation in notes)

**Notes:**

As STFRC has not made any upgrades to the facility and monitoring technologies since their previous audit in 2018, the subparts of this standard are not applicable.

### §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): ICE Policy #11062.2, Sexual Abuse and Assault Prevention and Intervention, requires that "facilities secure and preserve the crime scene and safeguard information and evidence, consistent with ICE uniform evidence protocols and local evidence protocols in order to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." Policy #14-2-FRS requires that the "investigating entity shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." Additionally, the investigation "protocol shall be developmentally appropriate for youth where applicable, and as appropriate, shall be adapted from or otherwise based on the most recent edition of the Department of Justice's Office of Violence against Women publication, A National Protocol for Sexual Assault Medical Forensic Protocols developed after 2011." In speaking with the SDDO, the ICE uniform evidence protocol is the STFRC's assumed protocol for any facility-based crime scene. In speaking with medical staff, it was noted that forensic exams are conducted by the local hospital in accordance with protocols based on the DOJ's Sexual Assault Nurse Examiner and Sexual Assault Forensics Examiner (SANE/SAFE) standards.

(b): According to Policy #14-2-FRS, the "investigating entity shall attempt to make available to the victim a victim advocate from a rape crisis center." The STFRC IHSC policy, LOP #03-02, utilizes the Rape Crisis Center of San Antonio for this purpose; CoreCivic, Policy #14-2-FRS, utilizes both the Rape Crisis Center of San Antonio and Children's Alliance of South Texas for this purpose. The facility's use of these agencies for these services was confirmed through an interview with the PSA Compliance Manager. Accordingly, the Auditor also reached out to both agencies to discuss their abilities to facilitate advocacy efforts. A response from the Rape Crisis Center of San Antonio was not received. However, Children's Alliance of South Texas did confirm that they would provide victim advocate services if needed. Copies of both MOUs were reviewed and affirmed that both agencies will provide victim advocate services to residents as needed.

(c): Policy #14-2-FRS requires that the facility provide residents alleging sexual abuse with qualified medical treatment performed by a SAFE/SANE whenever possible. The service must be provided at no cost to the victim. Additionally, Texas law, specifically, Texas HB 616, Article 56.06, prohibits a fee from being assessed to any victim for a forensic medical exam. Interviews with medical staff found that the STFRC utilizes Methodist Hospital Specialty and Transplant, located in San Antonio, Texas. At that facility, SANEs are staffed 24 hours a day, 7 days a week. According to hospital staff, SANEs are "registered nurses having obtained advanced education with certification in conducting medical-forensic examinations using trauma informed care and providing expert testimony in a court of law." A copy of the MOU was reviewed to confirm that the hospital will use "evidence and forensic medical examination standards established in the Prison Rape Elimination Act (PREA) 28 C. F. R. Part 115.21." In speaking with the ICE SDDO, it was affirmed that while there has not been an instance within the current auditing period requiring a forensic exam, the facility still follows all agency protocol regarding such.

(d): Policy #14-2-FRS notes "as requested by the victim, either the victim advocate, a qualified investigating entity staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals." In speaking with the PSA Compliance Manager, it was noted that victim advocate services would be provided to any resident requesting such following an instance of sexual abuse. In speaking with the ICE SDDO, it was affirmed that while there has not been an instance within the current auditing period requiring a forensic exam, the facility still follows all agency protocol regarding such.

(e): Policy #14-2-FRS requires that "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 Examination, as outlined below. If the facility is not responsible for investigating such allegations, the facility shall request that the responsible outside agency or entity comply with these requirements." Copies of MOUs between the STFRC and the Frio County Sheriff Department, as well as the City of Dilley Police Department were reviewed. In this, it was noted that the Dilley Police Department would conduct criminal investigation specific to sexual abuse in accordance with 6 CFR 115.22, sections (a)-(e). In speaking with the Facility Administrator, it was noted that local law enforcement, as well as ICE staff, would be notified in the event of sexual abuse allegations.

**§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): Policy #14-2-FRS, requires the Facility Administrator to "ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse or assault. All investigations into alleged sexual abuse must be conducted by qualified investigators." Copies of MOUs between the STFRC and the Frio County Sheriff Department, as well as the City of Dilley Policy Department, were reviewed. In this, it was noted that the Dilley Police Department would conduct criminal investigations specific to sexual abuse in accordance with 6 CFR 115.22, sections (a)-(e). In speaking with the Facility Administrator, it was noted that local law enforcement, as well as ICE staff, would be notified in the event of sexual abuse allegations. In speaking with the ICE SDDO, it was affirmed that an administrative or criminal investigation is completed for all allegations of sexual abuse. 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 resident 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 resident-on-resident allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who 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 Investigative 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.

(b)(c): MOUs between the STFRC and the Frio County Sheriff Department, as well as the City of Dilley Policy Department, provide a description of the responsibilities of the agency, the facility, and other investigative entities. In speaking with the STFRC PSA Compliance Manager and the ICE SDDO, the agency's supporting role in the investigatory process was discussed at great length. Specifically, it is the responsibility of STFRC to notify local law enforcement of all sexual abuse allegations involving potentially criminal behavior. The STFRC will secure the crime scene pending the arrival of local law enforcement. STFRC staff will then assist and cooperate with local law enforcement during the investigation process. This protocol has been posted on the agency web for public review. The ICE website, 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. The South Texas Family Residential Center website provides facility specific information regarding PREA: corecivic.com/facilities/south-texas-family-residential-center.

(d)(e)(f): Policy #14-2-FRS requires "all allegations of sexual abuse shall be promptly reported to a law enforcement agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior." Policy #14-2-FRS, mandates that at the STFRC, regardless of the alleged perpetrator, the following law enforcement agencies are notified in accordance with the standard: Dilley Police Department, ICE/ERO On-Site Assistant Field Office Director who will notify the ICE FOD, DHS Office of Inspector General, ICE OPR, and Joint Intake Center (JIC). Interviews with the Facility Administrator, ICE SDDO, and the PSA Compliance Manager confirm this notification protocol is, in fact, followed as required. Additionally, three investigation files were reviewed to ensure timely notifications were provided to the appropriate law enforcement, ICE, and DHS staff.

**§115.31 - Staff training.**

**Outcome:** Exceeds Standard (substantially exceeds requirement of standard)

**Notes:**

(a)(b): Policy #14-2-FRS requires that "all CoreCivic facility employees shall receive training on CoreCivic's zero-tolerance policy for sexual abuse and assault. Such training shall be tailored to the gender and age of the residents at the facility. At a minimum, all employees shall receive pre-service and annual in-service training on the following: The DHS PREA Standards and other applicable ICE policy; federal, state, or local laws imposing criminal liability for the sexual abuse of a person held in custody; an employee's duty to report any occurrence of sexual abuse and assault; how to fulfil employee responsibilities for sexual abuse and assault prevent detection reporting, and response in accordance with this policy; the right of residents and staff to be free from sexual abuse and from retaliation for reporting sexual abuse and assault; definitions and examples of prohibited and illegal sexual behavior; recognition of situation were sexual abuse and assault may occur, recognition of physical, behavioral, and emotional signs of sexual abuse and assault, and methods of preventing and responding to such occurrences; how to avoid inappropriate relationship with residents; how to communicate effectively and professionally with residents, including LGBTI and Gender Non-Conforming residents; procedures for reporting knowledge or suspicion of sexual abuse and assault; and the requirements to limit reporting of sexual abuse and assault to personnel with a need to know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes." A review of the Corrections Corporation of America's (CCA) Sexual Abuse and Assault Prevention/Intervention (SAAPI) PowerPoint curriculum verified the minimum information conveyed during course trainings. In speaking with training staff, it was noted that information specific to proper search procedures and sexual abuse prevention and response was provided to all resident supervisors during pre-service and then again during every annual in-service training. Additionally, it was noted that other staff, contractors, and volunteers also receive training specific to sexual abuse prevention and response. During security staff interviews including line staff and first-line supervisors, all employees explained their continuous training received specific to sexual abuse. CoreCivic employees commonly stated they received in-person PREA training during annual in-Service, as well as an additional training six months later via computer format. Also, during the weekly staff meetings, PREA is often a topic of discussion. A review of 7 employee files, 3 contractor files, and 3 volunteer files found all persons compliant with required training. Given the totality of the compliance measures noted above, including annual training and computer training every six months, the facility has exceeded the minimum requirements of this standard.

(c): Policy #14-2-FRS requires that a 14-2A PREA Training and/or Policy Acknowledgement form is completed by each employee who receives PREA training. A copy of this form is then placed in each employee's file. In speaking with training staff, it was noted that employees are required to complete this form when they receive PREA training. Additionally, copies of this form were observed in seven employee files and three contractor files.

**§115.32 - Other training.**

**Outcome:** Exceeds Standard (substantially exceeds requirement of standard)

**Notes:**

(a)(b)(c): Policy #14-2-FRS requires that "all civilians/contractors who have contact with residents shall receive training on their responsibilities pertaining to sexual abuse and assault prevention, detection, reporting, and response as outlined in this policy. The level and type of training provided to civilians/contractors shall be based on the services they provide and level of contact they have with residents. All civilians/contractors who have contact with residents shall be notified of CoreCivic's zero-tolerance policy regarding sexual abuse and assault and informed how to report such incidents. Civilians/contractors shall be required to confirm, either electronic or manual signature, their understanding of the received training. The 14-2A-PREA Training and/or Policy Acknowledgment form serves as verification of the civilian (volunteer) or contractor's review and understanding of the contents of the zero-tolerance policy and training. Signed documentation will be maintained in the civilian (volunteer) or contractor's file." When interviewing contractors, all stated that they had received PREA training. In fact, said contractors noted how much the facility emphasized PREA training and adherence to the PREA standards. A review of three contractor files reflected that all persons reviewed had completed their initial sexual abuse training, as well as subsequent training where appropriate. Given the totality of the compliance measures noted above, the facility has certainly exceeded the minimum requirements of this standard. More specifically, the contractors interviewed met the basic requirements of the standard in that they not only received annually PREA training, but also received PREA training at six-month intervals.

**§115.33 - Detainee education.**

**Outcome:** Does not Meet Standard (requires corrective action)

**Notes:**

(a): Policy #14-2-FRS notes that "during the intake process, all residents shall be provided written information regarding sexual abuse and assault prevention and reporting. An orientation program will be conducted that includes instruction on the following topics: CoreCivic's zero-tolerance policy regarding all forms of sexual abuse and assault; prevention and intervention strategies; definitions and examples of resident-on-resident sexual abuse and assault, staff-on-resident sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse and assault, including to any staff member, to include a staff member other than an immediate point-of-contact line officer; information about self-protection and indictors of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting sexual abuse and assault shall not negatively impact the resident's immigration proceedings; and the right of a resident who has been subjected to sexual abuse and assault to receive treatment and counseling." During the intake process, residents are also provided a DHS-prescribed ICE Sexual Abuse and Assault Awareness pamphlet, an ICE Medical Orientation and Health Information pamphlet, a CoreCivic PREA Prevent, Detect, & Respond pamphlet, a Corrections Corporation of American (CCA) Preventing Sexual Abuse & Misconduct pamphlet, and a STFRC Family Staging Center Resident Manual, which contains all required PREA specific information. These pamphlets were issued in Spanish, as well as available in English upon request. The main language of the residents is Spanish. When the Intake Supervisor was asked about other languages including English, she stated there were handbooks and PREA information printed in English if needed. However, it took the Intake Supervisor a significant amount of time to retrieve and provide the Auditor this information in English. She indicated any other language would have to be translated and printed. While awaiting the initial intake screening, residents were directed to sit in the holding area. Within the holding area, there are two televisions designed for the continuous broadcasting of the agency's PREA Orientation Video. The video consists of 120 slides with captions provided in Spanish. The orientation video plays during the intake process while the residents are waiting for the ICE orientation and medical assessment. During one of the three on-site visits to intake, the television facing the resident sitting area was playing cartoons for the children to watch. The other television was playing the orientation; however, that television was toward the back of the waiting area and not visible to the majority of residents unless they were to turn their seats in the opposite direction. Hence, the majority of residents were sitting with their backs to the television and there was no audio. When the Intake Supervisor was asked about the television not being viewable by the residents, she stated that they will have the residents move their chairs to watch the video; however, during the three visits to intake, this was not observed by the Auditor. In the main dining area, there are televisions that continuously provide the facility orientation information, to include PREA information. While there isn't any sound to this broadcast, residents can read the captioned information (in Spanish) at the bottom of the screen. In interviewing residents, those who spoke Spanish generally noted that they had received and understood the PREA information

provided to them during intake. However, the majority of residents who did not speak Spanish stated that they were not able to understand the information conveyed to them during the intake process. A review of ten residents files showed no education documented.

(b): Policy #14-2-FRS requires sexual abuse training to be provided in a range of manners so as to accommodate residents with various disabilities, to include those who are "deaf or hard of hearing, blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities, in order to ensure said persons have an equal opportunity to participate in or benefit from all aspects of the facility efforts to prevent, detect, and respond to sexual abuse. Such steps include, when necessary, the following: providing residents who are deaf or hard of hearing, with access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using necessary specialized vocabulary. Providing residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision with written materials related to sexual abuse in formats or through methods that ensure effective communication. For Limited English Proficient (LEP) residents, the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another resident." In interviewing ten resident supervisors, all staff affirmed their willingness to provide accommodations for residents requiring such. During the intake process, all residents receive written PREA information in Spanish. Most staff assigned to the intake department at STFRC speak both English and Spanish, of which, staff can provide Spanish speaking residents with PREA information. During the intake process, access to the language line allows all residents to audibly receive PREA information, as well as to receive a PREA assessment, in their native language. Accordingly, there is often more than one way that residents can receive information specific to sexual abuse in a meaningful way. The facility's library has copies of the PREA video in differing languages. As requested, residents are provided a DVD in the appropriate language. It should be noted that while the assumed language on the facility is Spanish, Residents at the STFRC have access to tablets, which can be used to translate the PREA information into any language. In the event a resident's language is not available via DVD, the PREA informational video can be translated using the tablet or language assistance line. Also, Purple, an American Sign Language program, is available for use on the tablets. However, despite American Sign Language being a universal language across all of North America and English-speaking Canada, it is not a natural Spanish language. In interviewing residents, those who spoke Spanish generally noted that they had received and understood the PREA information provided to them during intake. However, the majority of residents who did not speak Spanish stated that they were not able to understand the information conveyed to them during the intake process.

**Does Not Meet:** (a)(b) The facility is not providing meaningful education to the resident during the intake process. Residents are not receiving education based on interviews as well as lack of documented education in the residents' file review. The residents are not watching the orientation video that provides the PREA education. The PREA orientation video is not available in multiple languages or captioned for residents that do not understand Engligh, Spanish, or deaf and hearing impaired residents. The PREA video is not shown with volume for the hearing impaired or blind residents. The agency policy indicates the facility must provide residents with access to the video which includes both sight and sound. Otherwise, the PREA orientation is not being provided by the facility as the agency intends. While residents at the STFRC can obtain copies of the PREA video in differing languages at the facility library, the intake department should maintain its own copies of the PREA video in differing languages so that all residents, regardless of their natural language, will have equal opportunity to see and hear the information contained in the PREA video during the intake process. The facility must ensure that all residents have accessibility to the orientation material in a manner they understand which informs the residents about the agency and facility's zero-tolerance policy, prevention, and intervention strategies; definitions of sexual abuse; reporting methods; self-protection and indicators of sexual abuse; prohibition of retaliation; and the right to receive treatment and counseling in a language of manner the detainee understands. Additional documentation needed to confirm compliance will depend on the method(s) in which the facility employs to meet the standard requirements.

**Recommendation:** (b) To provide efficient and effective education, upon receipt of residents, the facility should identify the most common/natural language of the residents and play the appropriate language PREA videos in rotating order of the most common languages.

(c): Policy #14-2-FRS requires that "the facility shall maintain documentation of resident participation in educational sessions pertaining to sexual abuse and assault." However, a review of ten resident files found 60% had missing or incomplete documentation of resident education. Commonly, when special assistance was provided, specifically when the language line was utilized, there was no documentation denoting such. Additionally, documentation reflecting the appropriate PREA information provided at intake was inconsistent. Sometimes the information was noted and sometimes it wasn't.

**Does Not Meet:** Resident education was not documented in 60% of the resident files. The facility must maintain documentation of resident education in the intake process orientation. The intake process should create a system that ensures staff properly document all sexual abuse and assault education provided to residents. To demonstrate compliance, the facility must provide ten examples for resident education in the intake process for three months, which includes examples of LEP and disabled residents.

(d): Policy #14-2-FRS requires that the "facility shall post on all housing unit bulletin boards the following notices: The DHS prescribed sexual assault awareness notice; the name of the Compliance Manager; and the name of local organizations that can assist residents who have been victims of sexual abuse and assault." While two of those requirements, the name of the Compliance Manager; and the name of local organizations that can assist residents who have been victims of sexual abuse and assault, were missing at the onset of the on-site review, they were both addressed and corrected prior to the conclusion of the review. As such, no further action is needed. The neighborhood activity rooms contain the required PREA informational posters and zero-tolerance notices in both English and Spanish. Inside these rooms, there were also poster size advisement notices of the rape crisis center for emotional support. However, these notices were only displayed in Spanish. It was brought to the attention of facility staff that said notices should also be provided in English. Corrective action was immediately taken. Informational sheets in English advising residents of the rape crisis center were posted throughout the facility's activity rooms prior to the end of the on-site review.

(e): Policy #14-2-FRS requires that "the facility shall make available and distribute the DHS-prescribed Sexual Assault Awareness Information pamphlet." While the facility does provide this information, all of the pamphlets observed as distributed during the on-site review were in Spanish. Since several groups of residents primarily communicate in languages other than Spanish, the information, as provided, wasn't meaningful.

**Does Not Meet:** The facility is not providing meaningful access to the DHS-prescribed Sexual Assault Awareness Information pamphlet for residents who do not read in languages other than Spanish and English. The DHS-prescribed Sexual Assault Awareness Information pamphlet is currently available in nine different languages. STFRC should obtain copies of this pamphlet in all nine languages to have readily available for distribution as needed.

**Recommendation**: The Auditor recommends the DHS-prescribed Sexual Assault Awareness Information pamphlet, in both English and Spanish, be available or posted in the activity rooms as well.

(f): In speaking with PSA Compliance Manager, because the STFRC is a family residential center, it is not required to provide residents with an ICE National Detainee Handbook. The STFRC does, however, provide residents with the STFRC Resident Handbook which includes PREA information. The ICE Detainee National Handbook is available in the library if a resident wanted to read or reference information within the handook verified by the Auditor.

### §115.34 - Specialized training: Investigations.

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

**Notes:**

(a)(b): Policy #14-2-FRS requires that "in addition to the general training provided to all employees, and to the extent that CoreCivic conducts sexual abuse and assault investigations, investigators shall receive training on sexual abuse and assault investigations, conducting effective cross-agency coordination, techniques for interviewing sexual abuse and assault victims, and sexual abuse and assault evidence collection. The facility shall retain written documentation verifying this training." In interviewing the ICE SDDO, the additional training required in excess of general PREA training for both CoreCivic and ICE staff was explained. A review of documentation indicates that additional training was completed and that documentation supporting that is maintained as required for those employees who serve as investigators on PREA allegations. The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, that covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the ICE SharePoint to document compliance with the standard.

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

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

**Notes:**

(a)(b)(c): Policy #14-2-FRS mandates that "in addition to the general training provided to all employees, all full and part-time Qualified Health Care Professionals and Qualified Mental Health Professionals, who work in the facility, shall receive specialized medical training as outlined below: how to detect and assess signs of sexual abuse and assault; how to preserve physical evidence of sexual abuse and assault; how to respond effectively and professionally to victims of sexual abuse and assault; how and to whom to report allegations of sexual abuse and assault; and how to preserve physical evidence of sexual abuse and assault." All medical services are provided by ICE Health Service Corps (IHSC). A review of the IHSC training specific to ICE IHSC Sexual Abuse and Assault Prevention and Intervention curriculum demonstrated the depth of additional training required. The two medical/mental health training records reflect that staff have received said training as required and verified the accuracy of the training rosters. Additionally, during the interview process, said staff stated that they had received additional, specialized medical and mental health training in excess of the generally required training. Lastly, medical staff interviewed stated that while medical staff assigned to the STFRC do not perform forensic exams, appropriately qualified medical staff are trained in procedures for examining and treating victims of sexual abuse.

### §115.41 - Assessment for risk of victimization and abusiveness.

**Outcome:** Does not Meet Standard (requires corrective action)

**Notes:**

(a): Policy #14-2-FRS requires that "the facility shall assess all adult residents upon intake to identify those likely to be sexual perpetrators or sexual abuse and assault victims and shall house residents to prevent sexual abuse and assault, taking necessary steps to mitigate any such danger. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly." As observed during the on-site review, new arrivals are kept separate from the general population via the intake holding area pending their classification and housing assignment. A review of the sexual abuse screening tool verifies the questions work to determine those residents likely to be sexual perpetrators and those likely to be victims. As well, in speaking with the Resident Supervisor and intake staff, the value of the screening tool was discussed in depth. Specifically, the screening tool asks seven questions, as well as requires seven staff observations of the resident, to determine likely victimization status. The seven staff observations are: resident appears to be physically, developmentally, or mentally disable; resident has a small build or appears to be vulnerable; resident appears to be gender non-conforming: lesbian, gay, bisexual, transgender, or intersex; resident appears to be a loner, introverted, or naïve; resident has a youthful or elderly appearance which may contribute to vulnerability; resident has not been previously incarcerate or detained; and resident has no history of criminal or institutional violence. The screening tool then asks five questions and requires one staff notation to determine likely predatory status; this notation is whether the resident has a security threat group affiliation. The screening tool further allows staff to note any discrepancies between the file and the current screening event. The language line number is posted in each intake desk for staffs' reference. The language line allows all residents to audibly receive PREA information, as well as to receive a PREA assessment, in their native language. While most persons assigned to the intake department at STFRC speak both English and Spanish, there are still significant differences in Spanish dialects across Spanish speaking countries. As well, the PREA assessment contains formalized words which may not be commonly used in an individual staff member's personal vocabulary of language specific words. For example, the Auditor observed the administration of the PREA assessment during the on-site review, the staff member was not sufficiently fluent in Spanish. The Auditor observed the staff member asking a second staff member how to translate specific English words. This would suggest that person still may or may not have adequate knowledge of the Spanish language to fully interpret the respondent's answers, especially considering regional dialects. Accordingly, if a staff member administering the PREA assessment in the Spanish language is not fully aware of how one should formally express specific words within the PREA screening instrument, said staff should utilize the language line to engage the entire PREA screening instrument as written. The Auditor also observed staff completing the risk assessment without asking the questions of the resident. The Auditor observed three intakes over the three-day on-site visit. Two of those risk assessments, the staff member completed the risk assessment without asking all the questions of the resident. And one of the two, the staff member did not speak fluent Spanish to communicate with the resident as noted above.

**Does Not Meet:** The facility is not completing meaningful risk assessments of residents. Questions are being completed without asking the resident and staff not fluent in the language of the resident is completing the risk assessment without utilizing the language line. The facility needs to ensure residents are assessed through asking the questions of the resident and in a language the resident understands. A recommended corrective action for

this issue includes the facility creating a system or process to be used during intake screenings that ensure staff properly conduct all risk assessments in the resident's native language, as well as ask and document all responses to all questions noted on the risk screening tool. To demonstrate compliance, the facility must provide the system or process developed to ensure staff are properly conducting risk assessments including utuilizing the language line wen necessary and completing all questions through the interview with the resident. The staff must be trained on the new system or process and documentation of the training provided for compliance review.

(b): Policy #14-2-FRS requires that "residents shall be screened, and the initial housing assignment should be completed within twelve (12) hours of admission to the facility." Ten detainee files were reviewed and 90% of those admissions were completed within 12 hours.

(c)(d): Policy #14-2-FRS requires that "the facility shall consider, to the extent that the information is available, the following criteria to assess resident for risk of sexual victimization: whether the resident has a mental, physical, or developmental disability; the age of the resident; the physical build and appearance of the resident; whether the resident has previously been detained; the nature of the resident's criminal history; whether the resident has any convictions for sex offenses against an adult or child; whether the resident has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; whether the resident has self-identified as having previously experienced sexual victimization; and the resident's own concerns about his/her physical safety." The policy also states, "the initial screening shall consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing residents for risk of being sexually abusive." A review of the sexual abuse screening tool verifies the questions as stated. As well, in speaking with the Resident Supervisor and intake staff, the screening tool was discussed in depth. Specifically, the screening tool asks seven questions, as well as requires seven staff observations of the resident, to determine likely victimization status. The screening tool then asks five questions and requires one staff notation to determine likely predatory status. The screening tool further allows staff to note any discrepancies between the file and the current screening event.

(e): Policy #14-2-FRS notes that "the facility shall reassess each resident's risk of victimization or abusiveness between sixty (60) and ninety (90) days form the date of the initial assessment. The reassessment will include any additional relevant information received by the facility since the initial intake screening; and when warranted, due to a referral, request, incident of sexual abuse, or receipt of additional information that may impact the resident's risk of victimization or abusiveness." Residents are generally assigned to the facility for approximately five days. It should be noted that in none of the 10 resident files reviewed, was the resident housed at the STFRC longer than 60 days. Additionally, of the 3 sexual abuse incident files reviewed, none of the residents were still assigned to the facility 60 days after the alleged incident. However, in speaking with facility case managers, it was noted that if the need to reassess a resident did present itself due to new information that might impact the resident's risk, certainly a reassessment would be made.

(f): Policy #14-2-FRS stipulates that "residents shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to the Sexual Abuse Screening Tool." In speaking with intake staff, it is noted that residents have a right to refuse to answer. If they do, no retaliatory measures can be taken against them.

(g): Policy #14-2-FRS notes that "the facility shall implement appropriate controls on the dissemination of responses to questions asked pursuant to this screening, to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. These controls, include, but are not limited to conducting screenings and assessments in as private an area as possible so that conversation is not overhead by other staff or residents; restricting computer access to screen and assessment records only to staff who need this information to complete assignments directly related to this policy; and ensuring hard copies of screening and assessment forms are secured when not in use by authorized staff and are not accessible to residents." In speaking with the PSA Compliance Manager, it is noted that residents' records are restricted to only staff with a bonified need for such access. For example, intake staff have access to resident records, but only to the extent needed to complete the intake process.

**§115.42 - Use of assessment information.**

**Outcome:** Does not Meet Standard (requires corrective action)

**Notes:**

(a)(b): Policy #14-2-FRS states that "the facility shall use the information obtained from the 14-2B-FRS Sexual Abuse Screening Tool completed at initial screening in the assignment of housing, recreation, voluntary work programs, and other activities. Individualized determinations shall be made on how to ensure the safety of each resident." Residents are assessed via the Sexual Abuse Screening Tool upon intake. However, regardless of targeted factors identified during the assessment, all residents are assigned housing based on their family matrix. They are then scheduled to be seen by the Unit Team at the next opportunity for a Unit Team Meeting. Lastly, protocol requires housing assignments to be determined based on the PREA screening assessment, suicide screening assessment, and the family matrix. In this, if a resident affirmatively responds to being a member of a PREA protective class, that person is extracted from the housing assignment process and must be seen by the Unit Team prior to being permanently assigned to any housing suite. However, if the PREA screening assessment is administrated after normal business hours and Unit Team members are not at the facility to hold a formal team meeting with the identified resident, standard operating procedure dictates the resident is placed in general population housing, in accordance with the family matrix, until such time as Unit Team members arrive at the facility the following day and hold a formal team meeting. To ensure sexual safety, standard operating procedure further dictates that person will be housed separately within a suite in the appropriate neighborhood of the family matrix. When the Intake Supervisor was asked how the housing assignments were made, she stated it is based on the family matrix only. Per Policy #14-2-FRC, as well as the Facility Administrator, the STFRC does accept transgender or intersex residents.

**Does Not Meet:** (a) The facility makes housing decisions solely based on the family matrix without considering the risk assessment. The facility is not following policy #14-2-FRS to make individual housing determinations to ensure the safety of the resident. The facility must consider information from the risk assessment to make informed assignments of residents to housing, recreation, other activities, and voluntary work. For compliance determination, the facility must provide ten examples for three months of the information from the risk screening being utilized for housing decisions, and the consideration must be documented.

**Recommendation**: Facility protocol should be updated to include the standard operating procedure.

(c): The STFRC does not accept transgender or intersex residents. As such, Policy #14-2-FRC states that "upon notification of the arrival or identification of a transgender or intersex resident, that resident will remain in the intake area and ICE/ERO shall be notified immediately." In speaking with the Facility Administrator, as well as random staff and residents, there was no indication that a transgender or intersex resident had ever been assigned to the STFRC.

**§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)(e): Policy #14-2-FRS advises that "Family Residential Centers do not operate Special Housing Units or Administrative Segregations Units." The lack of any Special Housing Units was discussed with the Facility Administrator. As such, it was noted that the STFRC cannot place any residents within a special housing unit. In the event that a person is received into the STFRC who requires special housing, that resident is held in the Intake area pending transfer to a facility that can accommodate the needed housing assignment. The policy was last reviewed and approved by DHS on April 17, 2017. As such, the STFRC complies with this standard in every way.

**§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): Policy #14-2-FRS notes that "residents shall be encouraged to immediately report pressure, threats, or instances of sexual abuse and assault, as well as possible retaliation by other residents or employees for reporting sexual abuse and staff neglect or violation of responsibilities that may be contributed to such incidents." In educating residents, Policy #14-2-FRS, among many other policies, provides residents with the contact information to their "consular official, the DHS Office of Inspector General, or as appropriate, another designated office, to confidentially and, if desired, anonymously report these incidents." The STFRC has created a Resident Telephone Book for easy access to their phone numbers. The facility provides residents with instructions on how to put more minutes on a phone card in the event the resident wishes to use those minutes to report allegations of sexual abuse. STFRC provides residents with a list of free phone call numbers, to include rape crisis centers, Consulates in Washington, D.C. and other major cities, information on how to make an anonymous call for PREA, the ICE Detention Reporting and Information Line (DRIL) and the DHS OIG anonymous reporting line, and a listing of all state area codes. The DRIL was contacted by the Auditor using both a suite phone and a booth phone within the phone room. In both instances, the Auditor was able to access the sexual abuse reporting system of the DRIL without charge or providing any identifying information. In each of the three sexual abuse investigative files reviewed, the residents reported their concerns directly to staff, who then took appropriate action in escalating the report.

(c): Policy #14-2-FRS dictates that "employees shall take all allegations of sexual abuse and assault seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports." In speaking with all facility staff, there is a clear culture of concern for the well-being of the residents assigned to STFRC. As such, all staff interviewed believed firmly in the application of the PREA standards. Staff absolutely acknowledged their role in providing a sexually safe environment and affirmed their responsibility in immediately reporting any knowledge or threat of sexual abuse. As well, as soon as possible, staff acknowledged their responsibility in documenting any verbal report made. Upon review of the investigative files, staff reported allegations immediately upon notification.

**§115.52 - Grievances.**

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

**Notes:**

(a)(b): Policy #14-101, Resident Grievance System, allows that "grievances pertaining to PREA incidents or allegations of sexual abuse shall be processed in accordance with Department of Homeland Security regulations as outlined in CoreCivic Policy #14-2-FRS Sexual Abuse Prevention and Responses." Policy #14-2-FRS advises residents that formal grievances filed on matters related to sexual abuse will be removed from the Grievance schedule in order for it to be processed at a faster rate. In this, Policy #14-2-FRS notes that "residents will be permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. The facility shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse." The facility library and main dining area contain a Grievance/Mailbox, which is secured by a keyed lock. Review of the STFRC Resident Handbook provides a more detailed discussion on the grievance process. Also, in speaking with the Grievance Coordinator, it was noted that no such grievances have been filed within the past twelve months. A listing of grievances by subject confirms that statement.

(c)(d): Policy #14-101 removes the time-sensitive nature of PREA allegations from the purview of the lengthier grievance program. Policy #14-2-FRS then indicates that this will expediate staff responsiveness to immediate threats to "detainee health, safety, or welfare related to sexual abuse." Policy #14-2-FRS further notes that "facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment." In speaking with the Grievance Coordinator, it was noted that no such grievances have been filed within the past twelve months. Additionally, medical staff did not report having received any medical concerns specific to sexual abuse allegations within the past twelve months.

(e)(f): Policy #14-2-FRS requires that "the facility shall issue a decision on the grievance within five (5) days of receipt and shall respond to an appeal of the grievance decision within thirty (30) days. The facility shall send all grievances related to sexual abuse, and the facility's decisions with respect to such grievances, to the appropriate ICE Field Office Director at the end of the grievance process." In speaking with the Grievance Coordinator, it was noted that residents could obtain assistance for filing sexual abuse grievances from other residents, staff, or outside parties. In providing said assistance, staff should make every effort possible to do so in a timely manner.

**§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): Policy #14-2-FRS notes that "CoreCivic shall maintain or attempt to enter in Memorandums of Understanding (MOU), of other agreements, with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional for immigrant victims of crime." As noted by the PSA Compliance Manager, the STFRC has entered into a MOU with the Rape Crisis Center of San Antonio, Texas, to provide community resources and services that crisis victims need. Specifically, the MOU notes that the Rape Crisis Center of San Antonio, Texas, will be responsible for providing expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators.

(b)(c)(d): Policy #14-2-FRS notes that "the facility shall establish, in writing, procedures to include outside agencies in the facility's sexual abuse and assault prevention and intervention protocols, if such community resources are available." Notices for the Rape Crisis Center are displayed in all

complex activity rooms for emotional support services. These notices provide a toll-free number for emotional support for victims of sexual assault. However, these notices were only displayed in Spanish. It was brought to the attention of facility staff that said notices should also be provided in English. Corrective action was immediately taken. Informational sheets in English advising residents of the rape crisis center were posted throughout the facility's activity rooms prior to the end of the on-site review. Additionally, notices of National Social Service Resources (2021) provide the toll-free numbers to a wealth of social services, such as mental health, trauma, domestic violence, human trafficking, and sexual assault. Policy #14-2-FRS states that "the facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible." Furthermore, "residents shall be informed, prior to giving them access, of the extent to which such communications shall be monitored and the extent to which report of abuse will be forwarded to authorities in accordance to mandatory reporting laws." Residents are informed on the limitations of confidential conversations specific to phone calls via the STFRC Resident Handbook. In this, it is noted that CoreCivic staff do not monitor any resident phone calls; however, all calls are subject to monitoring by federal agencies. It should also be noted that the STFRC IHSC LOP #03-02, utilizes the Rape Crisis Center of San Antonio for this purpose, and CoreCivic, Policy #14-2-FRS, utilizes Children's Alliance of South Texas and Rape Crisis Center of San Antonio for this purpose. Accordingly, the Auditor reached out to both agencies to discuss their abilities to facilitate advocacy efforts. The Children's Alliance of South Texas affirmed their ability to provide victim advocate services to STFRC residents. A response from the Rape Crisis Center of San Antonio has not yet been received.

**Recommendation:** Although the posting of the English information sheets addressed the immediate information dissemination concern for the rape crisis centers, it is recommended that the facility still obtain the poster size advisement notices of the rape crisis center for emotional support in English to be displayed adjacent to the Spanish version.

### §115.54 - Third-party reporting.

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

(a): Policy #14-2-FRC explains the "the facility shall establish a method to receive third-party reports of sexual abuse and assault and shall post this information on the facility PREA link." STFRC notes that third-party reports of sexual abuse could be made to the DHS OIG, which provides its website, phone number, mailing address, and fax number in order for people to make their complaints, which can also be done anonymously and confidentially. CoreCivic also gives the contact information to its 24-hour ethics line. Alternatively, ICE ERO provides its DRIL as a toll-free service. This information is commonly posted throughout the facility for everyone's access. During the on-site review, access to the DRIL was tested from both a suite phone and a phone booth inside the phone room. There was no third-party reporting during the audit period; in each of the three sexual abuse investigative files reviewed, the residents reported their concerns directly to staff, who then took appropriate action in escalating the report.

### §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): Policy #14-2-FRC notes that "the facility shall require all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility, retaliation against residents 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." Policy also allows employees to privately report allegations of sexual abuse of a resident by submitting a sealed letter, marked confidential, to the Facility Administrator. As well, employees may also report allegations of sexual abuse online to the CoreCivic's Ethics Hotline. In interviewing random staff their duty to report was clearly known to them. Also, the majority of staff understood how to make a confidential report. The facility has provided policy #14-2-FRC to the agency for review and approval.

(b)(c): Policy #14-2-FRC requires that "staff members who become aware of alleged sexual abuse shall immediately follow the reporting requirements set forth in this policy in sections G, Coordinated Response/Sexual Abuse Response Team (SART) and M, Response Procedures." Policy #14-2-FRC explained that "apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extend necessary, and as specified in this policy to make treatment, investigation, and other security and management decisions." During staff interviews, all staff recognized their duty to report. As well, they recognized the value in keeping it confidential after it was reported to the proper persons.

(d): Policy #14-2-FRC requires that "if the alleged victim is under the age of eighteen (18) or considered a vulnerable adult under a state or local vulnerable person's statue, the allegation shall be reported to the designated state of local services agency under applicable mandatory reporting laws." In discussing staff duty to report, the SDDO noted that all allegations involving victims under the age of eighteen would be reported to the Texas Department of Family and Protective Services (DFPS). During the audit period, there was one allegation regarding inappriopriate resident-on-resident contact. Documentation reflects that the Texas DFPS was notified as required.

### §115.62 - Protection duties.

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

(a): Policy #14-2-FRC notes that "upon receiving any information indicating that a resident is subject to a substantial risk of imminent sexual abuse or assault, any facility employee shall take immediate action to protect the resident." During random staff interviews, all staff stated that in the event a resident presented him/herself as being at risk of imminent sexual abuse, said staff responded that they would take immediate action to eliminate the threat or to protect the resident. There have not been any requests for said protection within the reporting time frame. Thus, there are no documents to review.

### §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): Policy #14-2-FRS requires "the Facility Administrator of the facility that received the allegation shall contact the Facility Administrator or appropriate office of the facility where the alleged abuse took place as soon as possible, but no later than seventy-two (72) hours after receiving the allegation." Policy #14-2-FRS stipulates that "should the facility be contacted by another agency or another facility reporting allegations of sexual abuse that reportedly occurred at any CoreCivic facility, the facility shall determine whether the allegation was reported and investigated. All such contacts and notification shall be documented on the 5-1B Notice to Administration; including the allegation, any details learned from the contact with the site

where the alleged abuse took place, and the facility's response to the allegation. If the allegation was not reported and/or not investigated, facility staff shall initiate reporting and investigation procedures in accordance with this policy." In speaking with the Facility Administrator, it was noted that the STFRC had not received any such complaints, either coming into the facility or going out of the facility, within the reporting time frame. Thus, there are no relevant documents for review. However, in speaking with the Facility Administrator, the notification requirements and relevant procedures were clearly explained. Specifically, as noted in Policy #14-2-FRS, once made aware of a SAAPI concern, "the PSA Compliance Manager, Administrator, or ADO will ensure that the ICE/ERO on-site Assistant FOD is notified."

**§115.64 - Responder duties.**

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

**Notes:**

(a): Policy #14-2-FRS notes that "upon learning of an allegation that a resident was sexually abused, the first security staff member to response to the report, or his/her supervisor, shall ensure that the alleged victim and perpetrator are separated and that the alleged victim is kept safe, and has no contact with the alleged perpetrator. The responder shall, to the greatest extent possible, preserve and protect any crime scene. If the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall request that the alleged victim not take any actions that could destroy physical evidence including, as appropriate, washing, brushing teeth, shower, changing clothing without medical supervision, urinating, defecating, smoking, drinking or eating." The first responder should also ensure "that the alleged perpetrator not take any actions that could destroy physical evidence, as noted above" per Policy #14-2-FRS. The STFRC has not had any incidents of sexual assault occur within the facility during the audit time frame that would create the need to preserve a crime scene or to preserve/collect possible DNA evidence on a victim/perpetrator. However, in speaking with facility staff, the need to protect the resident, along with securing the crime scene or any evidence on the perpetrator, was clearly known.

(b): Policy #14-2-FRS includes notation that "if the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." In reviewing the three sexual abuse investigative files, it was noted that in all three instances, the first responder was a non-security staff member. In each instance, the first responder did immediately notify security staff of the allegations, who subsequently elevated the allegations to a sexual abuse investigation. However, none of the three instances reviewed required the collection of physical evidence. Additionally, in speaking with non-security staff, the need to notify security staff as quickly as possible after becoming aware of the allegations, as well as requesting that the resident not take any action that might destroy physical evidence, was discussed.

For the three files reviewed, all were reported by the alleged victim, or victim's guardian, to non-security staff following the alleged incident. As such, there was no need to separate the alleged victim from the alleged abuser at the time of the incident. One incident involved sexual harassment, which would not require securing a crime scene. In this case, the alleged abuser did receive a temporary change in assignment so that the staff member was no longer allowed to work within the same neighborhood as the alleged victim. The second incident involved inappropriate touching during a medical examination. Pending the investigation, the alleged victim was not required to interact with the alleged abuser in order to receive medical treatment. The third case involved inappropriate touching of one juvenile detainee by another juvenile detainee, which was reported outside of the evidence collection time frame.

**§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): Policy #14-2-FRS outlines the STFRC institutional plan to coordinate actions taken by first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. In doing this, the STFRC has developed a Coordinated Response/Sexual Assault Response Team (SART) to address allegations of sexual abuse. In speaking to the Facility Administrator, it was noted that the Coordinated Response Plan was designed to provide victims of sexual abuse with the greatest amount of help and the least amount of overlap. It was further noted that because the plan is coordinated, all departments have specific responsibilities that are designed to complement, rather than duplicate, response efforts.

(c)(d): Policy #14-2-FRS requires that "if a victim of sexual abuse and assault is transferred between facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." Policy #14-2-21 also requires that if a victim is transferred to a non-DHS facility, as permitted by law, the sending facility informs the receiving facility of the victim's potential need for medical or social services. In speaking with the Facility Administrator, it was noted that the STFRC has not had any reports to/from other facilities regarding allegations of sexual abuse. As such, there were not any documents available for review.

**§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:**

(a): Policy #14-2-FRS requires that "staff suspected of perpetrating sexual abuse and assault shall be removed from all duties requiring resident contact pending the outcome of an investigation. Contractors and civilians suspected of perpetrating sexual abuse and assault shall be removed from all duties requiring resident contact pending the outcome of an investigation." In speaking with the PSA Compliance Manager, it was further noted that should the results of the investigation be substantiated against the staff, contractor, or volunteer, termination/removal from service is the presumptive disciplinary. During the audit period, the facility had one substantiated allegation of staff misconduct of a sexual nature. Said employee was, in fact, terminated for those actions.

**§115.67 - Agency protection against retaliation.**

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

**Notes:**

(a)(b)(c): Policy #14-2-FRS prohibits retaliation against any person, including a resident who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or participates in sexual activity as a result of force, coercion, threats, or fear of force. To monitor for acts of retaliation, the PSA Compliance Manager will "ensure that thirty/sixty/ninety (30/60/90) day monitoring is conducted by the designated staff, following a report of an allegation of sexual abuse and assault, to protect against potential retaliation against residents or employees. This shall include periodic status checks of residents and review of relevant documentation (including any resident disciplinary reports, housing or program changes, or

negative performance reviews or reassignments of staff). Monitoring shall continue beyond ninety (90) days if the initial monitoring indicates a continuing need." In speaking with the PSA Compliance Manager, it was noted that if retaliation were suspected, agency policy requires that swift actions are taken, dependent on the engaged retaliation, to correct for any recognized retaliation. In speaking with the Retaliation Monitor, it was also noted that within the reporting time period, there have not been any documented allegations of retaliation for reporting PREA/SAAPI allegations. A review of the three investigative files noted that retaliation monitoring began within five days of the reported allegations. In one investigation, the resident was released seven days after making the report. In another investigation, retaliation monitoring continued at approximately 30 days intervals for 120 days. However, in the third instance, while retaliation monitoring began on the same day of the allegations, there is no evidence of actual status checks being completed anytime during the next 14 weeks that the resident was assigned to the facility. The facility has met substantial compliance with two of the three files documented monitoring.

**Recommendation:** The facility should develop standard operating procedures to ensure that retaliation monitoring occurs as required by facility policy.

### §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)(b)(c)(d): Policy #14-2-FRS states that "residents considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate." The STFRC is a Family Residential Center. As such, it does not operate Special Housing Units or Administrative Segregation Units. As such, victims cannot be placed in protective custody. In the event that a person is received into the STFRC who requires special housing, that resident is held in the Intake area pending transfer to a facility that can accommodate the needed housing assignment. In speaking with the PSA Compliance Manager, it was noted that the facility does not operate administrative segregation cells.

### §115.71 - Criminal and administrative investigations.

**Outcome:** Does not Meet Standard (requires corrective action)

**Notes:**

(a)(b): As Policy #14-2-FRS applies to criminal investigations, "the Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse or assault. All investigations into alleged sexual abuse must be conducted by qualified investigators. Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate." As discussed with the ICE SDDO, administrative investigations are conducted only after consultation with the appropriate investigative office inside of the DHS, as well as the assigned criminal investigative authority. In speaking with the SDDO, it was noted that said staff were appropriately trained to conduct administrative investigations. Additionally, a review of employee training records reflects documentation to support said training. However, of the three investigative files reviews, none contained documented evidence of administrative investigations having been completed; the Auditor saw only emails and notifications, but there was no documentation of an administrative investigation completed per the requirements of subpart (c).

**Does Not Meet:** (a)(b) Agency policy requires an administrative investigation to be conducted for all allegations of sexual abuse or assault. However, of the three investigative files reviewed, none contained documented evidence of administrative investigations completed; the Auditor saw only emails and notifications, but there was no documentation of an administrative investigation completed per the requirements of subpart (c). The facility must develop standard operating procedures to ensure that administrative PREA investigations occur, and are subsequently prompt, thorough, objective, and documented, after all allegations of sexual abuse. Additional documentation needed to confirm compliance will depend on the method(s) in which the facility employs to meet the standard requirements.

(c): Policy #14-2-FRS demonstrates, and conversations with the PSA Compliance Manager support the claim that the facility has developed written procedures for administrative investigations. The procedures for administrative investigations include: preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as resident, staff , or employee, and without requiring any resident who alleges sexual abuse and assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment and investigation facts and findings; and retention of such reports for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years. In speaking with the PSA Compliance Manager, said procedures and time frames were reinforced.

(e): Policy #14-2-FRS mandates that "the departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." In speaking with the ICE SDDO, it was noted that regardless of whether or not the staff member remains employed by the agency, the investigation into the employee's conduct will continue. In speaking with the PSA Compliance Manager, it was noted that the release or transfer of a detainee does not stop the investigation into sexual abuse.

(f): Policy #14-2-FRS requires that "the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." In speaking with the Facility Administrator, facility measures to stay informed on the status of an investigation; namely through open communication with local law enforcement, were noted. In speaking with the ICE SDDO, the cooperative efforts with outside investigators were discussed.

### §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) As required by Policy #14-2-FRS, "when an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse and assault are substantiated." In speaking with the ICE SDDO, preponderance of evidence was explained simply as something more than 50%.

**§115.73 - Reporting to detainees.**

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

(a): Policy #14-2-FRS notes that "when the resident is still in immigration detention, or where otherwise feasible, following an investigation into the resident's allegation that he/she suffered sexual abuse and assault at the facility, the resident shall be notified of the result of the investigation and any responsive action taken." In speaking with the ICE SDDO, it was noted that the resident notification is provided on a 14-2E-FRS Resident Allegation Status Notification form. The resident signs receipt of the form indicating that notification was received. The form is then filed in the resident's detainee file. A review of the three PREA investigative files noted that whenever possible; namely, when the resident has not been released, they are properly notified of the investigation disposition. In one case, the resident was released prior to the end of the investigation; in one case the resident was notified of the results, and in one case the resident was released two days after the investigation closed. The policy was approved by DHS.

**§115.76 - Disciplinary sanctions for staff.**

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

(a)(b)(c)(d): The facility has provided policies and procedures regarding disciplinary or adverse actions for staff to the agency for review and approval. The agency approved said policy; namely, #14-2-FRS on December 14, 2020. Policy #14-2-FRS recognizes that "employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic sexual abuse and assault policies. Termination shall be the presumptive disciplinary sanction for employee who have engaged in or attempted or threatened to engage in sexual abuse and assault. All terminations for violations of CoreCivic sexual abuse and assault policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, to the extent known." In speaking with the Facility Administrator, it was noted that the presumptive disciplinary action for sexual misconduct is termination. In speaking with staff, it was apparent that said staff did understand the consequences of engaging in, or being party to, sexual abuse and assault. During the audit period, the facility had one substantiated allegation of staff misconduct of a sexual nature. Said employee was, in fact, terminated for those actions.

**§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): Policy #14-2-FRS requires that "any civilian/volunteer or contractor who engages in sexual abuse shall be prohibited from contact with residents. The facility shall report incident of substantiated sexual abuse by a contractor or civilian/volunteer, to law enforcement agencies unless the behavior was clearly not criminal." As well, such incidents will also be reported to relevant licensing bodies to the extent known. Policy #14-2-FRS require that "contractors and civilians suspected of perpetrating sexual abuse and assault shall be removed from all duties requiring resident contact pending the outcome of an investigation."

(c): Lastly, it should be noted that "any other violation of CoreCivic sexual abuse and assault policies by a civilian or contractor may result in further prohibitions." In speaking with the Facility Administrator, it was noted that the presumptive disciplinary action for sexual misconduct is termination. In speaking with contractors, it was apparent that said staff did understand the consequences of engaging in, or being party to, sexual abuse and assault. Due to the current restriction of volunteers into the facility as a function of COVID-19, there weren't any volunteers available for interview. During the audit time frame, there weren't any allegations of sexual abuse against any contractors or volunteers. As such, there were no such files to review.

**§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): Policy #14-2-FRS mandates that "all residents found guilty of sexual abuse and assault shall be disciplined in accordance with the facility disciplinary procedures. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories." In speaking with the Facility Administrator, it was noted that the STFRC was not a detention center, but rather, a residential facility. As such, there isn't a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures at this facility and if a resident is found to have engaged in sexual misconduct, that individual is subsequently transferred to a detention facility to provide for the proper administration of disciplinary sanctions.

(c)(d): Policy #15-100, Behavior Management, requires that "each facility will have an administrative resident behavior management system with progressive levels of investigations, reviews, appeals, procedures, and documentation requirements." In this, "facilities will not hold a resident accountable for his/her conduct if the Clinical Medical Authority (CMA) finds him/her mentally incompetent." In speaking with mental health staff, the concept of mitigating factors as they apply to the disciplinary hearings was discussed in depth. Specifically, how mental illness affects culpability was discussed.

(e)(f): Policy #14-2-FRS stipulates that "a resident may be disciplined for sexual conduct with an employee only upon a finding that the employee did not consent to such contact. Residents who deliberately allege false claims of sexual abuse and assault can be disciplined. However, a report of sexual abuse and assault 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 the investigation does not establish sufficient evidence to substantiate the allegation." In speaking with the Facility Administrator, it was noted that residents are not disciplined for filing allegations of sexual abuse unless it could be proven that the resident knowingly filed a false allegation.

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

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

(a)(b)(c): Policy #14-2-FRS states that "if screening indicates that a resident has experienced prior sexual victimization, staff shall, as appropriate, ensure that the resident 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 resident shall receive a health evaluation no later than two (2) working days from the date of the assessment. When a referral for mental health follow-up is initiated, the resident shall receive a mental health evaluation no later than seventy-two (72) hours after the referral." In interviewing intake staff, it was noted that referrals are made to medical and mental health in accordance with policy. During the intake process, a resident who disclosed sexual victimization was referred to mental health as observed by the Auditor. The

Auditor requested to see the resident file to confirm the referral and if the detainee was seen by mental health. By the end of the following day, that resident had, in fact, been seen by mental health. This provides evidence to suggest that upon referral, residents are being scheduled and seen by the appropriate medical/mental health staff. In discussing the referral process with mental health staff, it was noted that referrals are taken seriously, and residents are seen for any referral made. The facility could not provide a list of residents that had disclosed prior victimization; therefore, the Auditor was unable to review additional files.

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

**Outcome:** Does not Meet Standard (requires corrective action)

**Notes:**

(a)(b): Policy #14-2-FRS notes that "resident victims of sexual abuse and assault shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. Resident victims of sexual abuse and assault while detained shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professional accepted standards of care, where medically appropriate. Medical and mental health treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the perpetrator or cooperates with any investigation arising out the incident." In speaking with medical staff, it was noted residents are provided medical care in accordance with staff's professional judgement. It was further noted that forensic exams are not provided by facility staff, but rather residents would be taken to Methodist Hospital in San Antonio for a SAFE/SANE by qualified staff. In review of the three PREA investigative files for allegations of sexual abuse, it was noted that none of the residents were seen by medical or mental health following their reports of sexual abuse. The Auditor also requested to review medical notes documenting the resident was seen by medical, the medical files had no documentation to verify the residents were seen. Furthermore, the medical staff interviewed could not provide insight whether the resident was seen or not.

**Does Not Meet:** The standard and facility policy require that resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. However, of the three investigative files reviewed, there wasn't any documented evidence to suggest that residents received any medical or mental health treatment following their reported allegations. The Auditor recommends the facility develop a standard operating procedure to ensure that medical and/or mental health referrals occur, and are subsequently evaluated, after all allegations of sexual abuse or assault. At a minimum, the facility should be able to provide evidence, whether as part of the investigative file, medical file, or some other means, that resident victims were provided this care in accordance with the requirements. The Auditor will either need evidence that the resident victims in the three PREA investigative files received care in accordance with the requirement, or evidence that future victims during the corrective action period received said treatment.

**§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): Policy #14-2-FRS notes the "the facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse or assault in a detention facility. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility shall provide such victims with medical and mental health services consistent with the community level of care." In speaking with medical staff, the medical department's role in sexual abuse examinations; namely, the need to transfer residents to an outside hospital for forensic services or other medical treatment, and provide on-going medical and mental health care as needed, was discussed. In this, it was confirmed that the facility would transfer residents to appropriate facilities for medical and mental health treatment as deemed necessary.

(d)(e)(f): Policy #14-2-FRS provides that "resident victims of sexually abusive vaginal penetration by a male perpetrator while detained shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy related medical services and timely access to these services. Victims of sexual abuse shall be offered tests for sexually transmitted infections as medically appropriate. Medical and mental health treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the perpetrator or cooperates with any investigation arising out of the incident." In speaking with medical staff, it was noted that forensic exams are conducted by local hospitals. Residents are not charged for these services. Additionally, upon return to the facility, residents would be provided any other related services, such as tests for sexually transmitted infections, without charge. In speaking with mental health staff, it was noted that crisis intervention services are also provided without charged.

(g): Policy #14-2-FRS provides that the facility will "attempt to conduct a mental health evaluation of all known resident-on-resident perpetrators within sixty (60) days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." Additionally, in speaking with mental health staff, the timely and continued role of mental health evaluations was discussed. In this, the need for crisis intervention immediately following allegations of sexual abuse, as well as the continued need for mental health services to help address mental health needs following the initial crisis intervention were noted.

**§115.86 - Sexual abuse incident reviews.**

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

**Notes:**

(a)(b): Policy #14-2-FRS requires that "the Facility Administrator will ensure that a post investigation review of a sexual abuse and assault incident is conducted at the conclusion of every sexual abuse and assault investigation and, where the allegation was not determined to be unfounded, prepare a written report with thirty (30) days of the conclusion of the investigation. The Review Team shall: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse and assault, Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification; status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; and examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area my enable abuse." In speaking with both the Facility Administrator and the PSA Compliance Manager, the aforementioned information is, in fact, considered following every incident review. Additionally, the three PREA investigative file reviews support the time requirements for review are being met as required, specifically, within 30 days of the concluded investigation.

(c): Policy #14-2-FRS requires that "the facility shall conduct an annual review of all of the sexual abuse investigations and resulting incident review to assess and improve sexual abuse and assault intervention, prevention and response efforts… The results and finds of the annual review shall be provided to the Facility Administrator, FSC PSA Coordinator, ICE FOD, and the ICE PSA Coordinator." In speaking with the PSA Compliance Manager, it

was noted that the facility does, in fact, prepare an annual review of said incidents. The Auditor reviewed a copy of last annual review competed, which occurred on April 2, 2021.

**§115.87 - Data collection.**

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

**Notes:**

(a): In speaking the PSA Compliance Manager, the location of all case records associated with claims of sexual abuse, including files such as incident reports, investigative reports, and offender information, are maintained in a secure area; specifically, within a secured filed cabinet inside of the AFA's office.

**§115.201 - Scope of audits.**

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

**Notes:**

(d): The Auditor was provided complete access to the facility, to include access to staff and residents.

(e): The Auditor was provided access to relevant documentation as required while on-site. Upon leaving the facility, access to documents or other reference information continued via the ICE ERAU SharePoint.

(i): The Auditor was provided a private space to interview both staff and residents. The room was located within the visitation area.

(j): Audit notices were posted throughout the facility in both English and Spanish. The Auditor did not receive any correspondents form residents assigned to the STFRC.

**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:** | 32 |
| **Number of standards not met:** | 6 |
| **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.

*Valerie Wolfe Mahfood* 8/13/2021

**Auditor's Signature & Date**

(b) (6), (b) (7)(C) 8/13/2021

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

(b) (6), (b) (7)(C) 8/13/2021

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

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

Homeland Security

| AUDITOR INFORMATION | | | |
|---|---|---|---|
| **Name of Auditor:** | Valerie Wolfe Mahfood | **Organization:** | Creative Corrections, LLC. |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | 315-255-(b) (6), (b) |
| **PROGRAM MANAGER INFORMATION** | | | |
| **Name of PM:** | (b) (6), (b) (7)(C) | **Organization:** | Creative Corrections, LLC. |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | 772-579-(b) (6), (b) |
| **AGENCY INFORMATION** | | | |
| **Name of agency:** | U.S. Immigration and Customs Enforcement (ICE) | | |
| **FIELD OFFICE INFORMATION** | | | |
| **Name of Field Office:** | San Antonio | | |
| **Field Office Director:** | Jose Correa | | |
| **ERO PREA Field Coordinator:** | (b) (6), (b) (7)(C) | | |
| **Field Office HQ physical address:** | 1777 Northeast Interstate 410 Loop 100, San Antonio, Texas, 78217 | | |
| **Mailing address:** *(if different from above)* | | | |
| **INFORMATION ABOUT THE FACILITY BEING AUDITED** | | | |
| **Basic Information About the Facility** | | | |
| **Name of facility:** | South Texas Family Residential Center | | |
| **Physical address:** | 300 El Rancho Way, Dilley, Texas, 78017 | | |
| **Mailing address:** *(if different from above)* | | | |
| **Telephone number:** | 830-378-6500 | | |
| **Facility type:** | FRC | | |
| **Facility Leadership** | | | |
| **Name of Officer in Charge:** | (b) (6), (b) (7)(C) | **Title:** | Facility Administrator |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | 830-965-(b) (6), (b) |
| **Facility PSA Compliance Manager** | | | |
| **Name of PSA Compliance Manager:** | (b) (6), (b) (7)(C) | **Title:** | Assistant Facility Administrator |
| **Email address:** | (b) (6), (b) (7)(C) | **Telephone number:** | 512-709-(b) (6), (b) |

## FINAL DETERMINATION

**SUMMARY OF AUDIT FINDINGS:**

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the South Texas Family Residential Center (STFRC), located in Dilley, Texas, was conducted May 25-27, 2021. The purpose of this audit was to determine compliance with the DHS PREA standards. The audit was conducted by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Dr. Valerie Wolfe Mahfood and accompanying the Auditor was (b) (6), (b) (7)(C) Immigration and Customs Enforcement (ICE) PREA Program Manager, both contractors employed by Creative Corrections, LLC. Guidance and review of the CAP Final Determination report writing process was provided by the ICE PREA Program Manager, (b) (6), (b) (7) [redacted] and Assistant ICE PREA Program Manager, (b) (6), (b) (7)(C) who are both DOJ and DHS certified PREA Auditors. The role of the Program Manager is to provide oversight to the ICE PREA audit process and liaison with the ICE External Reviews and Analysis Unit (ERAU) during the audit report review process. This CAP Final Determination Report was prepared by the APM (b) (6), (b) (7)(C) in the absence of the Auditor.

The STFRC is privately operated by CoreCivic and operates under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility houses resident families with juvenile children pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the most populated nationalities assigned to the STFRC are from El Salvador, Guatemala, and Honduras. This is the second PREA audit for STFRC. Note: as of the publication of this report, STFRC is no longer housing resident families with juvenile children.

The point of contact for the audit was (b) (6), (b) (7)(C) Section Chief, ERAU/ICE, Office of Professional Responsibility (OPR). About one month prior to the audit, the Team Lead provided the Auditor with the facility's PAQ, facility and agency policies, exhibits, and other pertinent documents. The documentation was provided through the ICE ERAU SharePoint. This documentation was reviewed by the Auditor prior to the on-site visit.

During the audit, the Auditor found the STFRC met 32 standards; exceeded 2 standards (115.31, 115.32); had 1 standard not applicable (115.18); and 6 standards that did not meet (115.16, 115.33, 115.41, 115.42, 115.71, 115.82). As a result, the facility was placed under a corrective action period to address the non-compliant standards. The facility provided a corrective action plan (CAP) for all non-compliant standards during the corrective action period, which has now expired, and the facility demonstrated full compliance with all standards.

Documentation was provided by the facility and agency in response to the CAP and reviewed by the Auditor for an initial review on or about November 24, 2021. CAP documentation was provided and/or reviewed by the APM on February 7, 2022, March 21, 2022, and April 6, 2022. The facility's 180-day CAP deadline was February 9, 2022.

During the review of the CAP documents on March 21, 2022, the APM discovered that some of the documentation previously requested by the Auditor had not been received for review and the missing documentation was necessary in order to determine implementation of the CAP and subsequent compliance with the standards. After consultation with ERAU, the facility was permitted the remaining 48 hours in their 180-day CAP period to provide the documentation previously requested by the Auditor as evidence of CAP implementation within the corrective action period for the standards which remained non-compliant at that time, and for which the requested documentation had not been provided (115.16, 115.33, 115.41, and 115.42). The facility provided the requested documentation for the Auditor/APM's review which demonstrated compliance with the remaining non-compliant standards. On April 6, 2022, the APM accepted the CAP as fully completed and the facility was found to meet all standards.

## PROVISIONS

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

**§115. 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 14-2-FRS, appropriate steps are not being taken to ensure that residents with disabilities or those who are LEP 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. As was explained to the Auditor, residents who are deaf or hard of hearing are provided access to an American Sign Language interpreter via electronic tablet. That said, it's unlikely that an immigrant entering the country is going to already know how to communicate via American Sign Language. As such, it would be more appropriate for a sign interpreter of the resident's native language. The spoken language and the written language also carry the same concern. At intake, all residents received PREA orientation in Spanish. For the significant majority of Spanish speaking residents in intake, that was fine. But for the smaller percentage of residents who did not speak Spanish, or didn't speak it well, the language translation services were not always being used to translate PREA information to residents who are limited English/Spanish proficient. For residents who are blind or have limited reading skills, sexual abuse information can be provided in an audible format. However, it should be noted at intake, the PREA Orientation Video was being played with muted sound; and therefore, not providing the PREA information in a manner a blind or limited reading skill detainee can understand. Mental health counselors are available to assist those residents with intellectual disabilities. In interviewing residents, the majority of them spoke Spanish. With the exception of one such resident, all native Spanish speaking residents stated that they received the PREA information in a meaningful way. Two other language groups were interviewed, with the sole resident in one group (Romanian) stating that staff had used the language line to communicate with her. In the second group of residents, Spanish is a typical second language for many citizens of their county (Haiti). However, three residents interviewed from Haiti all expressed that they had limited Spanish proficiency. Thus, it was difficult for them to understand the PREA information in a meaningful way as it was provided in Spanish. In speaking with the PSA Compliance Manager, it was stressed that regardless of the resident's disability, to include limited English/Spanish proficiency, the facility would make every effort possible to educate those residents on the agency's zero-tolerance policy.

During the Intake process, access to the language line allows all residents to audibly receive PREA information, as well as to receive a PREA assessment, in their native language. While most persons assigned to the intake Department at STFRC speak both English and Spanish, there are still significant differences in Spanish dialects across Spanish speaking countries. As well, the PREA assessment contains formalized words which may not be commonly used in an individual staff member's personal vocabulary of language specific words. For example, in administrating the PREA assessment during the on-site review, a staff member who was not sufficiently fluent in Spanish was observed asking a second staff member how to translate specific English words into Spanish. This would suggest that the staff still may or may not have adequate knowledge of the Spanish language to fully interpret the resident's answers, especially considering regional dialects. Accordingly, if a staff member administering the PREA assessment in the Spanish language is not fully aware of how one should formally express specific words within the PREA screening instrument, it is recommended that said staff utilize the language line to engage the entire PREA screening instrument as written.

**Does Not Meet (a)(b):** For residents who are blind or have limited reading skills, sexual abuse information was not provided in an audible format, and the language translation services were not always being used to translate PREA information to those residents who are limited English/Spanish proficient. The facility must take appropriate steps to ensure residents with disabilities or those who are LEP 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.

**Corrective Action (a)(b):** The facility provided a 7-step CAP in response to the non-compliance. 1) Upon arrival at the facility, the native language spoken by each new resident shall be determined by facility staff using the I Speak Language Identification Guide; 2) During the Intake Process, residents who are able to read and understand English or Spanish shall be provided with the appropriate English or Spanish version of the DHS pamphlet entitled "Sexual Assault Awareness Information" and the Facility Resident Handbook; 3) English and Spanish speaking residents shall confirm that they have received the DHS pamphlet and the respective information in the Facility Resident Handbook by signing the SAAPI Information Acknowledgement Form; 4) Residents who are unable to speak or read English or Spanish shall have the DHS Sexual Assault Awareness Information pamphlet and the respective information in the Facility Resident Handbook (pages

43-47) translated for them in their native language through use of the Language Line. Use of the Language Line, including the language spoken and interpreter ID shall be noted on the SAAPI Information Acknowledgement Form; 5) English and Spanish speaking residents who are blind, cognitively impaired, or have limited reading skills shall have the DHS Sexual Assault Awareness Information pamphlet read to them by facility staff; 6) Residents who are Hearing Impaired shall have the DHS Sexual Assault Awareness Information pamphlet signed to them using the Language Line Sign language interpreter service, while those unable to read shall have the DHS Sexual Assault Awareness Information pamphlet read to them; 7) The telephone number and address of the San Antonio Rape Crisis Center shall be posted in housing areas and common areas in both English and Spanish. This information is included in the SAAPI related section of the Facility Resident Handbook (pages 43-47) and would be communicated to the resident during the translation of this information as noted in step #4 above. Residents may call this number for emotional support.

The facility provided supporting documentation as evidence of implementation of this CAP which was reviewed by the APM and included the Resident Handbook; DHS PREA Pamphlet; the I Speak Language ID Guide; Intake SAAPI Information Acknowledgement Forms; Operations Memorandum 2022-001; and photographs of the Rape Crisis Center postings on detainee bulletin boards. Additionally, the facility provided 10 examples of signed STFRC Orientation for New Residents, Form 17-100G, completed between the dates of 12/01/2021-01/29/2022 for LEP residents. These languages included Romanian, Portuguese, Russian, French, Russian, Spanish, Uzbek, and Mandarin. Each signed form was accompanied by copies of case notes from the corresponding detainee's file which clearly noted the date orientation was conducted, and the use of an interpreter using their telephone language service during delivery, to include the language spoken. While the facility did not provide the specific evidence of delivery of the ICE Detainee Handbook as requested by the Auditor, the evidence provided indicates that the facility is substantially meeting the requirements of 115.16. The facility demonstrated compliance with all subparts of this standard and the facility meets this standard in all material ways.

**§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-FRS notes that "during the intake process, all residents shall be provided written information regarding sexual abuse and assault prevention and reporting. An orientation program will be conducted that includes instruction on the following topics: CoreCivic's zero-tolerance policy regarding all forms of sexual abuse and assault; prevention and intervention strategies; definitions and examples of resident-on-resident sexual abuse and assault, staff-on-resident sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse and assault, including to any staff member, to include a staff member other than an immediate point-of-contact line officer; information about self-protection and indictors of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting sexual abuse and assault shall not negatively impact the resident's immigration proceedings; and the right of a resident who has been subjected to sexual abuse and assault to receive treatment and counseling." During the intake process, residents are also provided a DHS-prescribed ICE Sexual Abuse and Assault Awareness pamphlet, an ICE Medical Orientation and Health Information pamphlet, a CoreCivic PREA Prevent, Detect, & Respond pamphlet, a Corrections Corporation of American (CCA) Preventing Sexual Abuse & Misconduct pamphlet, and a STFRC Family Staging Center Resident Manual, which contains all required PREA specific information. These pamphlets were issued in Spanish, as well as available in English upon request. The main language of the residents is Spanish. When the Intake Supervisor was asked about other languages including English, she stated there were handbooks and PREA information printed in English if needed. However, it took the Intake Supervisor a significant amount of time to retrieve and provide the Auditor this information in English. She indicated any other language would have to be translated and printed. While awaiting the initial intake screening, residents were directed to sit in the holding area. Within the holding area, there are two televisions designed for the continuous broadcasting of the agency's PREA Orientation Video. The video consists of 120 slides with captions provided in Spanish. The orientation video plays during the intake process while the residents are waiting for the ICE orientation and medical assessment. During one of the three on-site visits to intake, the television facing the resident sitting area was playing cartoons for the children to watch. The other television was playing the orientation; however, that television was toward the back of the waiting area and not visible to the majority of residents unless they were to turn their seats in the opposite direction. Hence, the majority of residents were sitting with their backs to the television and there was no audio. When the Intake Supervisor was asked about the television not being viewable by the residents, she stated that they will have the residents move their chairs to watch the video; however, during the three visits to intake, this was not observed by the Auditor. In the main dining area, there are televisions that continuously provide the facility orientation information, to include PREA information. While there isn't any sound to this broadcast, residents can read the captioned information (in Spanish) at the bottom of the screen. In interviewing residents, those who spoke Spanish generally noted that they had received and understood the PREA information provided to them during intake. However, the majority of residents who did not speak Spanish stated that they were not able to understand the information conveyed to them during the intake process. A review of ten residents files showed no education documented.

(b): Policy #14-2-FRS requires sexual abuse training to be provided in a range of manners so as to accommodate residents with various disabilities, to include those who are "deaf or hard of hearing, blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities, in order to ensure said persons have an equal opportunity to participate in or benefit from all aspects of the facility efforts to prevent, detect, and respond to sexual abuse. Such steps include, when necessary, the following: providing residents who are deaf or hard of hearing, with access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using necessary specialized vocabulary. Providing residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision with written materials related to sexual abuse in formats or through methods that ensure effective communication. For Limited English Proficient (LEP) residents, the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another resident." In interviewing ten resident supervisors, all staff affirmed their willingness to provide accommodations for residents requiring such. During the intake process, all residents receive written PREA information in Spanish. Most staff assigned to the intake department at STFRC speak both English and Spanish, of which, staff can provide Spanish speaking residents with PREA information. During the intake process, access to the language line allows all residents to audibly receive PREA information, as well as to receive a PREA assessment, in their native language. Accordingly, there is often more than one way that residents can receive information specific to sexual abuse in a meaningful way. The facility's library has copies of the PREA video in differing languages. As requested, residents are provided a DVD in the appropriate language. It should be noted that while the assumed language on the facility is Spanish, Residents at the STFRC have access to tablets, which can be used to translate the PREA information into any language. In the event a resident's language is not available via DVD, the PREA informational video can be translated using the tablet or language assistance line. Also, Purple, an American Sign Language program, is available for use on the tablets. However, despite American Sign Language being a universal language across all of North America and English-speaking Canada, it is not a natural Spanish language. In interviewing residents, those who spoke Spanish generally noted that they had received and understood the PREA information provided to them during intake. However, the majority of residents who did not speak Spanish stated that they were not able to understand the information conveyed to them during the intake process.

(c): Policy #14-2-FRS requires that "the facility shall maintain documentation of resident participation in educational sessions pertaining to sexual abuse and assault." However, a review of ten resident files found 60% had missing or incomplete documentation of resident education. Commonly, when special assistance was provided, specifically when the language line was utilized, there was no documentation denoting such. Additionally, documentation reflecting the appropriate PREA information provided at intake was inconsistent. Sometimes the information was noted and sometimes it wasn't.

(e): Policy #14-2-FRS requires that "the facility shall make available and distribute the DHS-prescribed Sexual Assault Awareness Information pamphlet." While the facility does provide this information, all of the pamphlets observed as distributed during the on-site review were in Spanish. Since several groups of residents primarily communicate in languages other than Spanish, the information, as provided, wasn't meaningful.

**Does Not Meet (a)(b):** The facility is not providing meaningful education to the resident during the intake process. Residents are not receiving education based on interviews as well as lack of documented education in the residents' file review. The facility must ensure that all residents have accessibility to the orientation material in a manner they understand which informs the residents about the agency and facility's zero-tolerance policy, prevention, and intervention strategies; definitions of sexual abuse; reporting methods; self-protection and indicators of sexual abuse; prohibition of retaliation; and the right to receive treatment and counseling in a language of manner the detainee understands.

**Does Not Meet (c):** Resident education was not documented in 60% of the resident files. The facility must maintain documentation of resident education in the intake process orientation. The intake process should create a system that ensures staff properly document all sexual abuse and assault education provided to residents.

**Does Not Meet (e):** The facility is not providing meaningful access to the DHS-prescribed Sexual Assault Awareness Information pamphlet for residents who do not read in languages other than Spanish and English. The DHS-prescribed Sexual Assault Awareness Information pamphlet is currently available in nine different languages. STFRC should obtain copies of this pamphlet in all nine languages to have readily available for distribution as needed.

**Corrective Action Taken (a)(b)(c)(e):** The facility provided a 7-step CAP in response to the non-compliance with (a)(b). 1) Upon arrival at the facility, the native language spoken by each new resident shall be determined by facility staff using the I Speak Language Identification Guide; 2) During the Intake Process residents who are able, to read and understand English or Spanish shall be provided with the appropriate English or Spanish version of the DHS pamphlet entitled "Sexual Assault Awareness Information" and the Facility Resident Handbook; 3) English and Spanish speaking residents shall confirm

that they have received the DHS pamphlet and the respective information in the Facility Resident Handbook by signing the SAAPI Information Acknowledgement Form; 4) Residents who are unable to speak or read English or Spanish shall have the DHS Sexual Assault Awareness Information pamphlet and the respective information in the Facility Resident Handbook (pages 43-47) translated for them in their native language through use of the Language Line. Use of the Language Line, including the language spoken and interpreter ID shall be noted on the SAAPI Information Acknowledgement Form; 5) English and Spanish speaking residents who are blind, cognitively impaired, or have limited reading skills shall have the DHS Sexual Assault Awareness Information pamphlet read to them by facility staff; 6) Hearing Impaired shall have the DHS Sexual Assault Awareness Information pamphlet signed to them using the Language Line Sign language interpreter service, while those unable to read shall have the DHS Sexual Assault Awareness Information pamphlet read to them; 7) The telephone number and address of the San Antonio Rape Crisis Center shall be posted in housing areas and common areas in both English and Spanish. This information is included in the SAAPI related section of the Facility Resident Handbook (pages 43-47) and would be communicated to the resident during the translation of this information as noted in step #4 above. Residents may call this number for emotional support.

The facility provided supporting documentation as evidence of implementation of this CAP which was reviewed by the APM and included the Resident Handbook; DHS PREA Pamphlet; the I Speak Language ID Guide; Intake SAAPI Information Acknowledgement Forms; Operations Memorandum 2022-001; and photographs of the Rape Crisis Center postings on detainee bulletin boards. Additionally, the facility provided 10 examples of signed STFRC Orientation for New Residents, Form 17-100G, completed between the dates of 12/01/2021-01/29/2022 for LEP residents. These languages included Romanian, Portuguese, Russian, French, Russian, Spanish, Uzbek, and Mandarin. Each signed form was accompanied by copies of case notes from the corresponding detainee's file which clearly noted the date orientation was conducted, and the use of an interpreter using their telephonic language service during delivery, to include the language spoken. While the facility did not provide evidence of delivery of the ICE Detainee Handbook as the Auditor requested, the evidence provided indicates that the facility is substantially meeting the requirements of 115.33. The facility demonstrated compliance with all subparts of this standard and the facility meets this standard in all material ways.

**§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): Policy #14-2-FRS requires that "the facility shall assess all adult residents upon intake to identify those likely to be sexual perpetrators or sexual abuse and assault victims and shall house residents to prevent sexual abuse and assault, taking necessary steps to mitigate any such danger. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly." As observed during the on-site review, new arrivals are kept separate from the general population via the intake holding area pending their classification and housing assignment. A review of the sexual abuse screening tool verifies the questions work to determine those residents likely to be sexual perpetrators and those likely to be victims. As well, in speaking with the Resident Supervisor and intake staff, the value of the screening tool was discussed in depth. Specifically, the screening tool asks seven questions, as well as requires seven staff observations of the resident, to determine likely victimization status. The seven staff observations are: resident appears to be physically, developmentally, or mentally disable; resident has a small build or appears to be vulnerable; resident appears to be gender non-conforming: lesbian, gay, bisexual, transgender, or intersex; resident appears to be a loner, introverted, or naïve; resident has a youthful or elderly appearance which may contribute to vulnerability; resident has not been previously incarcerate or detained; and resident has no history of criminal or institutional violence. The screening tool then asks five questions and requires one staff notation to determine likely predatory status; this notation is whether the resident has a security threat group affiliation. The screening tool further allows staff to note any discrepancies between the file and the current screening event. The language line number is posted in each intake desk for staffs' reference. The language line allows all residents to audibly receive PREA information, as well as to receive a PREA assessment, in their native language. While most persons assigned to the intake department at STFRC speak both English and Spanish, there are still significant differences in Spanish dialects across Spanish speaking countries. As well, the PREA assessment contains formalized words which may not be commonly used in an individual staff member's personal vocabulary of language specific words. For example, the Auditor observed the administration of the PREA assessment during the on-site review, the staff member was not sufficiently fluent in Spanish. The Auditor observed the staff member asking a second staff member how to translate specific English words. This would suggest that person still may or may not have adequate knowledge of the Spanish language to fully interpret the respondent's answers, especially considering regional dialects. Accordingly, if a staff member administering the PREA assessment in the Spanish language is not fully aware of how one should formally express specific words within the PREA screening instrument, said staff should utilize the language line to engage the entire PREA screening instrument as written. The Auditor also observed staff completing the risk assessment without asking the questions of the resident. The Auditor observed three intakes over the three-day on-site visit. Two of those risk assessments, the staff member completed the risk assessment without asking all the questions of the resident. And one of the two, the staff member did not speak fluent Spanish to communicate with the resident as noted above.

**Does Not Meet (a):** The facility is not completing meaningful risk assessments of residents. Questions are being completed without asking the resident, and staff not fluent in the language of the resident is completing the risk assessment without utilizing the language line. The facility needs to ensure residents are assessed through asking the questions of the resident and in a language the resident understands. A recommended corrective action for this issue includes the facility creating a system or process to be used during intake screenings that ensure staff properly conduct all risk assessments in the resident's native language, as well as ask and document all responses to all questions noted on the risk screening tool.

**Corrective Action Taken (a):** The facility developed a three step process in response to the non-compliance which included: 1) Upon arrival at the facility, the native language spoken by each new resident shall be determined by facility staff using available "I Speak" Posters designed for that purpose; 2) For residents who do not speak English or Spanish, intake staff shall utilize the Language Line to conduct Initial Risk Assessments using the CoreCivic 14-2B, Sexual Abuse Screening Tool. For staff who are not fluent in Spanish, the Language Line will be utilized. Staff will document usage of the Language Line on the appropriate log; and 3) All staff conducting Risk Assessments shall receive documented training on OMS (the offender management system), the 14-2B, and how to interview residents. Training shall be documented using CoreCivic 04-2A Training Rosters.

The facility provided documentation in support of the CAP for compliance review to address the policy, procedure, and staff training. The facility provided 10 completed risk assessments for LEP detainees processed between the period of 01/01/2022-02/08/2022; additionally, copies of computer generated InterpreTalk Language Services Detailed Reports of Service. The detailed reports identified the date, time, and language used when the InterpreTalk service was used. The APM reconciled calls from the detailed reports with the dates/times of the completed risk assessments which indicated corresponding dates and times to those on each of the risk assessments for the 10 LEP detainees. Based on information provided by the facility, the facility received no detainees requiring services for hearing or visual impairment during the CAP period. The facility demonstrated compliance with all subparts of 115.41 and the facility meets this standard in all material ways.

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

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

**Notes:**

(a): Policy #14-2-FRS states that "the facility shall use the information obtained from the 14-2B-FRS Sexual Abuse Screening Tool completed at initial screening in the assignment of housing, recreation, voluntary work programs, and other activities. Individualized determinations shall be made on how to ensure the safety of each resident." Residents are assessed via the Sexual Abuse Screening Tool upon intake. However, regardless of targeted factors identified during the assessment, all residents are assigned housing based on their family matrix. They are then scheduled to be seen by the Unit Team at the next opportunity for a Unit Team Meeting. Lastly, protocol requires housing assignments to be determined based on the PREA screening assessment, suicide screening assessment, and the family matrix. In this, if a resident affirmatively responds to being a member of a PREA protective class, that person is extracted from the housing assignment process and must be seen by the Unit Team prior to being permanently assigned to any housing suite. However, if the PREA screening assessment is administrated after normal business hours and Unit Team members are not at the facility to hold a formal team meeting with the identified resident, standard operating procedure dictates the resident is placed in general population housing, in accordance with the family matrix, until such time as Unit Team members arrive at the facility the following day and hold a formal team meeting. To ensure sexual safety, standard operating procedure further dictates that person will be housed separately within a suite in the appropriate neighborhood of the family matrix. When the Intake Supervisor was asked how the housing assignments were made, she stated it is based on the family matrix only. Per Policy #14-2-FRC, as well as the Facility Administrator, the STFRC does accept transgender or intersex residents.

**Does Not Meet (a):** The facility makes housing decisions solely based on the family matrix without considering the risk assessment. The facility is not following policy #14-2-FRS to make individual housing determinations to ensure the safety of the resident. The facility must consider information from the risk assessment to make informed assignments of residents to housing, recreation, other activities, and voluntary work.

**Corrective Action Taken (a):** The facility provided the revised 14-2 Policy, and 14-2B Sexual Abuse Screening Tool, as supporting documentation which reflect updated procedures. Intake staff will complete the assessment based on responses from the resident and make housing assignments accordingly. Any resident determined to be a predator by assessment will be placed on one-on-one observation and promptly transferred from the facility by ICE. The facility provided 10 completed risk assessments for LEP detainees completed between the period of 01/01/2022-02/08/2022 where 2 of the 10 indicated prior victimization along with a detailed explanation of how this information is used to make housing decisions. The blank risk assessment tool provided by the facility included the directions for completion which outlined the PREA alerts for the purpose of tracking predators, potential predators, victims and potential victims in their Offender Management System (OMS). Additionally, the facility provided a screenshot from the facility's OMS for a detainee who was determined to be a

"victim" based on the results of the risk assessment. The system flags the detainee accordingly for housing, and based on further information provided by the facility, the system will not allow assignment of a victim/potential victim to be housed in the same unit with a predator/potential predator.

While none of the examples provided indicated a detainee being assessed as a predator/potential predator, the facility sufficiently explained the facility's operating procedures if this was to occur. Based on responses from the risk screening instrument in Section II: Predatory History/Risk, residents are determined to be "predator, potential predator, or not applicable." Any predator or potential predator would have an alert automatically generated in OMS, similar to that as the victim alert described in the previous paragraph. Any resident identified as a predator or potential predator would remain in Intake under direct supervision, ICE would be notified, and the resident promptly transferred to another detention facility. The facility states that to date, there have been no predators/potential predators identified at STFRC.

Based on the evidence provided, the facility demonstrated compliance with all subparts of 115.42 and the facility meets this standard in all material ways.

**§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): As Policy #14-2-FRS applies to criminal investigations, "the Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse or assault. All investigations into alleged sexual abuse must be conducted by qualified investigators. Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate." As discussed with the ICE SDDO, administrative investigations are conducted only after consultation with the appropriate investigative office inside of the DHS, as well as the assigned criminal investigative authority. In speaking with the SDDO, it was noted that said staff were appropriately trained to conduct administrative investigations. Additionally, a review of employee training records reflects documentation to support said training. However, of the three investigative files reviews, none contained documented evidence of administrative investigations having been completed; the Auditor saw only emails and notifications, but there was no documentation of an administrative investigation completed per the requirements of subpart (c).

**Does Not Meet (a)(b):** Agency policy requires an administrative investigation to be conducted for all allegations of sexual abuse or assault. However, of the three investigative files reviewed, none contained documented evidence of administrative investigations completed; the Auditor saw only emails and notifications, but there was no documentation of an administrative investigation completed per the requirements of subpart (c). The facility must develop standard operating procedures to ensure that administrative PREA investigations occur, and are subsequently prompt, thorough, objective, and documented, after all allegations of sexual abuse.

**Corrective Action Taken (a)(b):** The facility provided the Auditor with a memorandum from the Facility Administrator to support the SAAPI Administrative Investigations will be conducted in accordance with requirements outlined in facility Policy 14-2-FRS (Sexual Abuse Prevention and Response). The Facility Investigator will be the designated Facility SAAPI Investigator. In the absence of the Facility Investigator, the Grievance Coordinator will be the designated Facility SAAPI Investigator. A certificate was presented for the backup investigator that confirmed completion of the Investigating Sexual Abuse in a Confinement Setting Web-Based Training Course through the National Institute of Corrections (NIC). Based on review of the Designated Facility SAAPI Investigator directive from the Facility Director, and evidence of investigator training for the designated employee, the APM accepts the corrective action as implemented and complete. The facility demonstrated compliance with all provisions of this standard in all material ways.

**§115. 82 - Access to emergency medical and mental health services**

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

**Notes:**

(a)(b): Policy #14-2-FRS notes that "resident victims of sexual abuse and assault shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. Resident victims of sexual abuse and assault while detained shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professional accepted standards of care, where medically appropriate. Medical and mental health treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the perpetrator or cooperates with any investigation arising out the incident." In speaking with medical staff, it was noted residents are provided medical care in accordance with staff's professional judgement. It was further noted

that forensic exams are not provided by facility staff, but rather residents would be taken to Methodist Hospital in San Antonio for a SAFE/SANE by qualified staff. In review of the three PREA investigative files for allegations of sexual abuse, it was noted that none of the residents were seen by medical or mental health following their reports of sexual abuse. The Auditor also requested to review medical notes documenting the resident was seen by medical; the medical files had no documentation to verify the residents were seen. Furthermore, the medical staff interviewed could not provide insight on whether the resident was seen or not.

**Does Not Meet (a):** The standard and facility policy require that resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. However, of the three investigative files reviewed, there wasn't any documented evidence to suggest that residents received any medical or mental health treatment following their reported allegations. The Auditor recommends the facility develop a standard operating procedure to ensure that medical and/or mental health referrals occur, and are subsequently evaluated, after all allegations of sexual abuse or assault. At a minimum, the facility should be able to provide evidence, whether as part of the investigative file, medical file, or some other means, that resident victims were provided this care in accordance with the requirements.

**Corrective Action Taken (a):** The facility/agency provided medical records for the three victims of sexual abuse for the three investigative files reviewed by the Auditor during the audit. This documentation provides evidence that all three victims were evaluated by medical within 24 hours of the reported incident, received a referral for a mental health evaluation and were seen as by a mental health practitioner. Based on the evidence presented, the APM concurs that detainee victims of sexual abuse were provided timely, unimpeded access to emergency medical treatment and crisis intervention services according to community standards of care. The APM accepts the corrective action provided as complete. The facility demonstrated compliance with standard 115.82 in all material ways.

**AUDITOR CERTIFICATION:**

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

*Sharon R. Shaver* April 17, 2022
**Auditor's Signature & Date**

(b) (6), (b) (7)(C) April 17, 2022
**Assistant Program Manager's Signature & Date**

(b) (6), (b) (7)(C) April 12, 2022
**Program Manager's Signature & Date**